GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD MEETING AGENDA

State of California
DEPARTMENT OF HEALTH CARE SERVICES

Notice is hereby given that the **Global Medi-Cal DUR Board** will conduct a public meeting on **Tuesday, September 18, 2018,** at the following location:

Department of Health Care Services
1700 K Street
1st Floor Conference Room
Sacramento, CA 95814
Registration link to attend meeting via webinar

9:30 AM-3:00 PM

Report Type*	Agenda Item	Presenter	Time
C	**1.** Welcome/Introductions/Introduce Ivana Thompson, PharmD, the new Chief of Pharmacy Operations Branch	Pauline Chan, RPh, MBA	930-940
A/D	**2.** Call to Order/Ground Rules/Review and Approval of Previous Minutes from May 22, 2018	Andrew Wong, MD	940-950
	3. Old Business		
I/A/D	**a.** Review of Board Action Items from May 22, 2018	Pauline Chan, RPh, MBA	950-955
I/D	**b.** Recommended Action Items for MCPs from May 22, 2018	Pauline Chan, RPh, MBA	955-1000
	4. New Business		
R/A/D	**a.** Global DUR Board Activities i. DUR Priorities: Survey Results	Andrew Wong, MD	1000-1015
	ii. Automatic Refill	Vic Walker, RPh	1015-1030
	b. Presentation: Leveraging Technology to Address the Opioid Crisis	Linette Scott, MD, MPH	1030-1055
Morning Break			1055-1100
R/D	**c.** Health Plan Presentations: San Francisco Health Plan i. 7 Day Limit on Initial Short-Acting Opioid Prescriptions ii. Home Blood Pressure Monitor Benefit Extension	Lisa Ghotbi, PharmD and Jessica Shost, PharmD [SFHP]	1100-1125
R/A/D	**d.** Presentation: Million Hearts® Initiative	Desiree Backman, DrPH, MS, RD	1125-1150
	e. Presentation: AB1114	Paul Pontrelli, PharmD	1150-1200
Lunch Break			1200-100

R/A/D	**f.** Prospective DUR: FFS i. New GCNs for 2Q2018 (April – June 2018) ii. Alert Priority Order iii. Ingredient Duplication Update: Emtricitabine, Lithium iv. Drug-Pregnancy Alert Update **g.** DUR Educational Outreach to Providers: FFS i. Proposal: Additive Toxicity ii. Outcomes: NRT, Opioids iii. Updated Outcomes: Early Refill, Fluoroquinolones **h.** Retrospective DUR i. FFS Quarterly Report: 2Q2018 (April – June 2018) ii. Review of FFS Physician Administered Drugs (PADs): 1Q2018 (January – March 2018) iii. Review of FFS CCS/GHPP Drugs (2017)	Amanda Fingado, MPH	100-155
	Afternoon Break		155-200
R/A/D	iv. Review of Retrospective DUR Criteria: Hypertension Medication Adherence **i.** Review of DUR Publications i. Bulletin (July 2018): Additive Toxicity ii. Alert (July 2018): Fluoroquinolones iii. Discussion/Recommendations for Future Bulletins	Shalini Lynch, PharmD	200-220
	j. FFY 2018 DUR Annual Report to CMS: Managed Care Survey Questionnaire	Lakshmi Dhanvanthari, MD, Jonathan Yeh, PharmD, and Kristen Tokunaga, PharmD [HPSJ]	220-230
	k. FFY 2018 DUR Annual Report to CMS: Companion Guide/FAQ	Pauline Chan, RPh, MBA and Sheila Thompson	230-240
R/I/A/D	**l.** Pharmacy Update i. Hepatitis C Policy Revision ii. Prescription Drug Overdose Prevention Initiative iii. Academic Detailing – 2017 Follow-up iv. Dissemination of DUR Educational Bulletins v. ADURS Recommended Minimum Standards **m.** Recap of today's action items **n.** Looking ahead: Call for future meeting agenda	Pauline Chan, RPh, MBA	240-250
C	**5.** Public Comments **		250-300
I	**6.** Consent Agenda		
	a. Meeting feedback **b.** Next meeting: November 27, 2018 1700 K Street 1st Floor Conference Room Sacramento, CA 95814 **c.** Proposed DUR Board Meeting Dates for 2019: Tuesday, February 26, 2019 Tuesday, May 21, 2019 Tuesday, September 17, 2019 Tuesday, November 19, 2019		
	7. Adjournment		300

* REPORT TYPE LEGEND: **A: Action**; **R: Report**; **I: Information**; **C: Comment**; **D: Discussion**

** Comments from the public are always appreciated. However, comments will be limited to five minutes per individual.

Picture identification is required to gain access to 1700 K Street. However, your security information will not be provided to the Global DUR Board.

You can obtain the Global DUR Board agenda from the Medi-Cal DUR Main Menu Web site (http://files.medi-cal.ca.gov/pubsdoco/dur/dur_home.asp).

Proposed Global Medi-Cal DUR Board Meeting Ground Rules

Andrew Wong, M.D.

Chair, Global Medi-Cal DUR Board

Proposed Global Medi-Cal DUR Board Meeting Ground Rules

- Be familiar with the Bagley-Keene Open Meeting Act
- Be familiar with Robert's Rules of Order
- Be courteous, respectful, and open minded of other's comments
- Be prepared by reviewing materials and downloading documents on PC/tablet in advance

Meeting Ground Rules (cont.)

- Review ground rules at the beginning of each board meeting
- Ground rules are subject to revision
- Copies of the Bagley-Keene Open Meeting Act and Robert's Rules of Order are available at each board meeting
- If approved, include ground rules in the Board Member Orientation Manual

GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD
MEETING MINUTES
Tuesday, May 22, 2018
9:30 a.m. – 3:00 p.m.

Location: Department of Health Care Services (DHCS)
1700 K Street, 1st Floor Conference Room
Sacramento, CA 95814

Topic	Discussion
1) CALL TO ORDER/ WELCOME/ INTRODUCTION	• Hannah Orozco, PharmD (Conduent) announced the new audiovisual equipment is now operational and that the microphones are highly sensitive and will pick up any side conversations. Dr. Orozco also informed the group that during the meeting if anyone in the audience would like to make a comment or ask a question, they should come stand by the microphone attached to the podium. • The Global Medi-Cal Drug Use Review Board (the "Board") members and meeting attendees introduced themselves. • DHCS staff present included Mike Wofford, PharmD, Dorothy Uzoh, PharmD, Pauline Chan, RPh, Paul Nguyen, PharmD, Marco Gonzales, PharmD, and Sheila Thompson. • Board members present: Drs. Timothy Albertson, Michael Blatt, Chris Chan, Jose Dryjanski, Stan Leung, Johanna Liu, Janeen McBride, Robert Mowers, Yana Paulson, Randall Stafford, Marilyn Stebbins, Andrew Wong, Iris Young, and Vic Walker. • Board members absent: Drs. Lakshmi Dhanvanthari and Ramiro Zuniga. • Representatives present from other Medi-Cal managed care plans included Amit Kurana, PharmD (Aetna), Edward Jai, PharmD (Inland Empire Health Plan), An Dinh, PharmD (Inland Empire Health Plan), and Tammie Chau, PharmD (San Francisco Health Plan) • The Chair of the Board, Dr. Andrew Wong, called the meeting to order. • Pauline Chan confirmed that we welcome use of the microphone for open comments. DHCS appreciates all comments and recommendations. She also advised the group that on occasion, DHCS may either not accept the recommendations of the Board or may choose alternative recommendations. • Dr. Wong stated that he is viewing an electronic copy of the agenda and packet in order to follow the agenda and attachments being presented. He explained that any Board members using personal computing devices during the meeting are viewing the same materials provided to the public. This statement is required by Open Meeting rules.

2) REVIEW AND APPROVAL OF MINUTES FROM MARCH 6, 2018	The Board reviewed the minutes from the Board meeting held on March 6, 2018. Dr. Albertson motioned that the minutes be approved. There was no discussion. The Board voted unanimously to approve the minutes. **AYE:** Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Walker, Wong, Young **NAY:** None **ABSTAIN:** None **ABSENT:** Dhanvanthari, Stebbins, Zuniga **ACTION ITEM**: Post the minutes from the Board meeting held on March 6, 2018.

3) OLD BUSINESS	**a.** Review of Action Items from Previous Board Meeting: i. Retrospective DUR Review: Hypertension – Ms. Chan stated that UCSF has been working on this review using data from across Medi-Cal, which is available in the MIS/DSS database. ii. Global DUR Board Subcommittee on Early Refill – Mr. Walker summarized the subcommittee discussion regarding hard edits for early refill. He stated that the subcommittee determined that hard edits would not work at this time, as there are limitations with the current system. In addition, he stated that DHCS is concerned about limiting access to medications by patients who need them. Mr. Walker is now proposing that a discussion is needed regarding the possibility of adding language to the pharmacy provider manual that would disallow or prevent automatic refills. A motion was made to add this to the agenda for the next DUR Board Meeting in September. There was no further discussion. The motion passed. **AYE:** Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Young **NAY:** None **ABSTAIN:** None **ABSENT:** Dhanvanthari, Zuniga **ACTION ITEM**: The Board recommendation to discuss the automatic refill policy further at the September 2018 Global DUR Board meeting will be submitted to DHCS. Dr. Stafford stated that he has yet to see the evidence that automatic refills are a problem and he worries about a policy that has the potential to impact patient adherence. Mr. Walker agreed that the argument in favor of automatic refills is improvements in patient adherence and compliance. Mr. Walker stated that an example of an area where it became a problem was in medical supplies, where 40% of the budget went to incontinent supplies that were being dispensed excessively due to automatic refills. He stated that patients called to complain about the excess. Dr. Liu asked the Board to consider during the discussion in September 2018 that Medicare has an established policy and MCPs have lines of business from both Medicare and Medicaid and to take into account the potential impact on having a different policy for each subset of patients. Lisa Ashton, PharmD (Johnson & Johnson) asked if shrinking the 100-day supply might help or reducing the number of refills on 100-day supplies. She suggested looking into what other states are doing to solve this problem. **b.** Recommended Action Items for MCPs – Ms. Chan presented the action items for MCPs from the last two Board meetings and thanked everyone for their extensive and thorough input and suggestions on how best to bring recommendations from the Global DUR Board back to the managed health care plans. Ms. Chan stated that these action item plans were developed by DHCS, with the first page listing required action items and the second page providing suggested action items. Ms. Chan presented the action items from both the November 28, 2017, and March 6, 2018, meetings. Ms. Chan stated that starting with this Board meeting, future recommended action items for MCPs will be available shortly after each meeting.

4) NEW BUSINESS	**a.** DUR Annual Report to CMS: FFY 2017 – Ms. Chan presented a summary of the highlights from the FFY 2017 report, which is the last annual report to focus exclusively on the Medi-Cal fee-for-service population. Dr. Walker asked about the status of the lock-in program for Medi-Cal beneficiaries. Ms. Chan explained that the lock-in program has changed from prior years and noted that every year the annual report questions pertaining to the lock-in program on the survey have been answered and confirmed in collaboration with the Audits & Investigations, Investigations Branch (IB).

Dr. Orozco presented program highlights that were provided as a part of the executive summary of the FFY 2017 report. There were no additional questions. A motion was made to approve the FFY2017 DUR Annual Report to CMS. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Zuniga

ACTION ITEM: The DUR Board recommendation to approve the FFY2017 DUR Annual Report to CMS will be submitted to DHCS.

b. DUR Annual Report to CMS for FFY 2018: Managed Care Survey Questionnaire – Health Plan of San Joaquin was originally scheduled to present, but due to an audit they were unable to attend the meeting today. Ms. Chan praised the Health Plan of San Joaquin (HPSJ) for making an early effort to use the questionnaire and to share lessons learned with the Board. Ms. Chan presented feedback she received from the HPSJ. There was some confusion regarding the Retrospective DUR section and whether plans should report the activities of the Global DUR Board or their own health plan activities. Ms. Chan stated that she reached out to CMS and they advised each plan to talk about their own retrospective DUR activities. Ms. Chan stated in cases where a Pharmacy and Therapeutics (P & T) Committee conducts DUR activities for a managed care plan, plans should list the functions of their P & T Committee and report on their DUR activities.

Dr. Khurana asked if the educational bulletins published by the Board and disseminated by the health plans are activities that should be included into the managed care plan annual report. Ms. Chan stated the mechanism for dissemination might differ by plan, but that the dissemination should be included in the annual report. Plans might consider posting a link to the DUR website that has all the educational alerts and bulletins or disseminating via other means via their P & T Committee.

Dr. Liu requested that a companion guide be compiled that could include summarized feedback and clarifications that could provide guidance to all plans. Ms. Chan welcomed the idea and stated that an FAQ is in-progress in response to request from the Pharmacy Director's meeting. Dr. Liu suggested an FAQ might not be as effective as a companion guide that could accompany the report and give guidance for specific questions as plans are completing the survey. Ms. Chan stated DHCS would be open to develop both the FAQ and a companion guide. Dr. Wong also wondered if HPSJ had already completed their draft, perhaps they would be willing to share it with other plans as additional guidance.

A motion was made that a companion guide to the FFY2018 DUR Annual Report to CMS be developed. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Walker, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Zuniga

ACTION ITEM: The Board recommendation to develop a companion guide to the FFY2018 DUR Annual Report to CMS will be submitted to DHCS.

Dr. Chan suggested an online questionnaire could easily identify discrepancies between plans at the presentation at the May 2019 Board meeting. Ms. Chan stated that while there may not be the ability to analyze all of the responses line-by-line, the important highlights would be covered. Dr. McBride asked if the intent was that each report would be made public. Ms. Chan stated this was her understanding, as each state annual report is currently

a public document available on the CMS website. Dr. Young asked about the compendium timeline. Ms. Chan suggested the compendium be ready by the September 2018 Board meeting, which would give plans six months to complete their report. She also noted that FFY 2018 ends September 30, 2018, just after the September 2018 meeting.

c. Retrospective DUR presented by Shalini Lynch, PharmD (UCSF)

i. Review of Retrospective DUR Criteria: Hypertension Medication Adherence – Dr. Lynch reviewed the methodology that will be used to measure adherence to hypertension medications and evaluate the use of home blood pressure monitoring (HBPM) devices. Dr. Stafford expressed frustration that this evaluation, which was requested at the March 6, 2018, Board meeting had not yet been completed by UCSF. Ms. Fingado stated that DHCS had been very supportive in facilitating access to MIS/DSS, there were logistical challenges and training requirements that could not be completed quickly enough to meet the April deadline for the review that is required for all posted Board meeting materials.

ii. Quarterly Report: 1Q2018 (January – March 2018) – Dr. Lynch presented the Medi-Cal fee-for-service quarterly DUR report for the 1st quarter of 2018, which includes both prospective and retrospective DUR data. She pointed out that the volume of therapeutic duplication (TD) alerts has increased 108% from the 1st quarter of 2017. She also stated that the DUR team would be working on an updated quarterly report for the 2nd quarter of 2018, which will include only fee-for-service beneficiaries in the utilization report, along with a separate carved-out drug report for those beneficiaries enrolled in Medi-Cal managed care plans.

Dr. McBride asked if the Board could review the alert priority order, which has not been reviewed for many years. Dr. Mowers agreed this would be helpful and asked if Conduent would also present a brief overview of the alerts and of the alert system at this time as well. A motion was made to review the alert priority. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Walker, Zuniga

ACTION ITEM: The Board recommendation to review the priority order of DUR alerts will be submitted to DHCS.

Dr. Mowers asked about those beneficiaries who are enrolled in the California Children's Services/Genetically Handicapped Persons Program (CCS/GHPP). He asked if it would be possible to conduct an evaluation of drug utilization in this population, similar to the reports on physician administered drugs (PADs). Ms. Fingado said this is something that could be presented at the next Board meeting in September. A motion was made to recommend a drug utilization review of the CCS/GHPP population. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to evaluate the drug utilization of CCS/GHPP enrollees will be submitted to DHCS.

iii. Review of FFS Physician Administered Drugs (PADs): 4Q2017 (October – December 2017) – Dr. Lynch showed a summary of paid claims for physician-administered drugs for the 4th quarter of 2017, which includes paid claims with dates of services between October 1, 2017, and December 31, 2017. These data were presented in three tables: 1) the top 20 drugs by total reimbursement paid to pharmacies, 2) the top 20 drugs by utilizing beneficiaries, and 3) the top 20 drugs by reimbursement paid to pharmacies per utilizing beneficiary. Dr. Lynch reminded the Board that effective July 1, 2017, Child Health and Disability Prevention (CHDP) claims processing officially transitioned to HIPAA compliant billing formats, which included a change where providers are now required to enter modifier SL (state-supplied vaccine) on vaccines supplied by the Vaccines for Children (VFC) program. While providers billing VFC procedure codes are reimbursed for vaccine administration costs only, these claims now appear in the quarterly PADs data. Dr. Lynch stated that claims for palivizumab are only billable from November to March (Q4 and Q1), which explains why there were no claims for this drug in the prior quarter (Q3 2017).

Dr. Blatt asked if there is a Medi-Cal policy regarding biosimilar drugs and if DHCS has a preference regarding which product is covered (biosimilar vs. non-biosimilar). Dr. Uzoh and Ms. Chan stated that they do not think that there is a current Medi-Cal policy regarding biosimilar drugs; however, they offered to look into it further and get back to the Board.

d. Review of DUR Publications presented by Dr. Lynch

i. Bulletin (March 2018): NRT in the Pharmacy – Dr. Lynch summarized the DUR educational bulletin, "In the Pharmacy: Pharmacists Furnishing Nicotine Replacement Products," which was published March 2018. The bulletin had the following three learning objectives:

- Review the California State Board of Pharmacy regulations for pharmacists to furnish nicotine replacement therapy (NRT) products, which have been in effect since January 2016.
- Describe strategies to promote smoking cessation in pharmacy practice
- Summarize best practices for responsible prescribing of NRT

Dr. Lynch provided some background information on California legislative requirements regarding pharmacist furnishing of NRT. The stated purpose of the new regulations is to provide timely access to NRT and to ensure that the patient receives information to appropriately initiate smoking cessation medication therapy.

Dr. Lynch described the results of a review of the Medi-Cal fee-for-service data that showed a total of 11,813 continuously eligible beneficiaries had least one paid pharmacy claim for an NRT product between March 1, 2016, and November 30, 2017. However, of the 21,763 total paid claims for NRT, only 260 paid claims (1%) were pharmacy-furnished. Dr. Lynch also reported that pharmacist-furnished NRT was more likely to be combination NRT (24% vs. 3% among all other providers). Dr. Lynch stated that among the study population, only 27 pharmacists in California furnished NRT, with more than half the paid claims coming from one practice location (SFDPH).

Dr. Lynch concluded that while the regulation allowing pharmacists in California to furnish NRT became effective over two years ago, there has not yet been widespread adoption in the Medi-Cal fee-for-service program. However, pharmacist-furnished NRT was more likely to be combination NRT therapy, and resulted in a greater number of paid claims per beneficiary. Dr. Lynch stated that educational outreach efforts may help to understand the barriers to adoption, as well as the facilitators present in pharmacy practices successful at furnishing NRT.

Dr. Lynch stated that clinical recommendations in this educational bulletin included the following:

- All pharmacist should complete the necessary training in order to furnish NRT products

- Identify and document current and past tobacco use or other nicotine use as a routine part of patient care
- Encourage active tobacco users to quit at every encounter, as multiple attempts are often required to treat tobacco dependence
- Furnish combination NRT therapy, which has been shown to be more effective at improving quit rates than NRT monotherapy
- Promote the California Smokers' Helpline at 1-800-NO-BUTTS

Dr. Stebbins noted that the low adoption by pharmacists is most likely a reflection of pharmacists not being reimbursed for these services. Dr. Stafford expressed the need to prioritize a payment model policy as soon as possible, given the urgency surrounding increased access to naloxone. Dr. Jai noted that the actual wording of the legislation states there is urgency and asked if it was possible if the Board could make a statement in support of timely resolution. Dr. Stebbins suggested DHCS look to other states like Oregon and Washington for guidance, as they both have implemented similar policies. Dr. Chan thought the payment implementation needed to be fully operational by 2021, so it might be worthwhile to gain insight from other states. Dr. Stebbins and Dr. Mowers both stated they would love the opportunity to ask questions to other states and find out more about how they handled topics that might be relevant to the Board, such as capitation issues. A motion was made to recommend reaching out to other states regarding the implementation of their pharmacist reimbursement policy. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to reach out to other states regarding the implementation of pharmacist reimbursement policy will be submitted to DHCS.

ii. Discussion/Recommendations for Future Educational Bulletins – The calendar for future DUR educational bulletins were reviewed. Dr. Lynch reported that two educational bulletins are currently in progress: 1) recent labeling changes for opioids and other CNS depressants (as well as the modifications made to the additive toxicity (AT) alert to identify beneficiaries at higher risk for adverse events); and 2) latent tuberculosis infection (LTBI) treatment dispensing errors in the pharmacy. Dr. Leung suggested covering the 12-dose LTBI treatment regimen and including information about the shorter course. Dr. Wong noted that there are have been dispensing errors associated with rifampin and rifapentine being sound alike drugs and the bulletin should include this as a counseling point.

Amanda Fingado, MPH (UCSF) noted that there was considerable positive feedback regarding the NRT bulletin and suggested that reviewing pharmacist-furnished hormonal contraception would also be of great interest to pharmacists and researchers. Dr. Liu suggested looking at days supply for hormonal contraceptives furnished by pharmacists. Dr. Leung agreed and stated that a review of pharmacist furnishing of naloxone should also be a priority. Ms. Chan noted that the 2018 core set measures for both adults and children also offered some important areas of interest for future bulletins and should replace the 2017 measures listed in the slide for future topics. A motion was made to add pharmacist-furnished naloxone to the educational bulletin topics. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to complete an educational bulletin regarding pharmacist furnishing of naloxone will be submitted to DHCS.

e. Opioids Initiative: Focus on Health Plans – Dr. Stafford summarized a discussion that occurred after the last Pharmacy Director's meeting on April 18, 2018, which involved a proposal to improve opioids stewardship with a focus on managed care health plans. The proposal, led by Dr. Stafford, was submitted by several Global DUR board members in response to a California Health Care Foundation Request for Proposal (RFP) for Opioid Safety Toolkit. The proposal led by Dr. Stafford was not awarded the grant. Dr. Stafford indicated the awardee was Manatt. Dr. Stafford reported that some of the health plans are very far along in adopting effective opioid stewardship policies and have initiated a number of interventions. Dr. Paulson highlighted the importance of plans being on the same page given the ability of patients to switch plans based on quantity limits and restrictions. Dr. Young stated that all plans involved in the discussion were on the same wavelength and had the same goal to achieve positive outcomes.

Dr. Stafford asked if DHCS had been contacted by Manatt. Ms Chan responded that she was not contacted. Dr. Paulson reported that LA Care and Kaiser had talked with Manatt.

Dr. Stebbins expressed concern regarding over quantity limits and the dangers that non-specific quantity limits can pose on discharged patients who require high doses of opioids. Dr. Paulson agreed that quantity limits are only one possible tool to help with opioid control.

f. Presentation: Pre-Exposure Prophylaxis (PrEP) Academic Detailing – The following three presenters from the Pacific AIDS Education Training Center (PAETC) Nancy Warren (Director of Evaluation), Portia Morris (Evaluation Associate), and Brian Abascal (Program Coordinator) gave a talk about their PrEP academic detailing pilot program, which began in September 2017 at UCSF. Each academic detailing session was approximately 15 – 30 minutes in length, and provided basic information about PrEP including its benefits, the steps needed to prescribe PrEP including lab work, payment options, and necessary follow-up assessment steps. The focus of the pilot program was on non-occupational PrEP and how providers can prescribe PrEP to prevent HIV and reduce health disparities. The academic detailer completed an evaluation for each of the 27 providers contacted.

Dr. Stebbins asked if the feedback from providers noted time constraints. Pacfic AETC stated that time constraints did not seem to be an issue and there was a general willingness to prescribe PrEP and a willingness to refer for PrEP. Dr. Stafford asked if the duration and intensity of the academic detailing was adequate. Pacific AETC said that the funding influenced the duration of the academic detailing sessions but they did follow-up with providers who were not quite ready to prescribe PrEP.

Ms. Chan asked how they would like the health plan medical and pharmacy directors to promote PrEP. Pacific AETC suggested referring those interested to Pacific AETC, as work can continue under federal funding. Ms. Chan asked if they were planning to train additional trainers for PrEP and Pacific AETC stated that had not yet been discussed. Dr. Blatt wondered if there had been any discussions regarding partnering with a pharmaceutical company. Pacific AETC stated that as a public health organization they would rather not associate with any particular pharmaceutical company.

g. Global DUR Board Activities – Dr. Wong led an open discussion with the Board and other plan representatives to share potential topics for Board priorities during FFY 2019.

- Dr. Mowers (University of California, Davis): His group has a large population of people with diabetes who are not stable. They reviewed the types of medications these patients were receiving and found common prescribing of dipeptidyl peptidase-4 (DPP-4) inhibitors as their third or fourth drug; however, their hemoglobin A1c (HbA1c) levels didn't reflect control. The most recent American Diabetes Association (ADA) guidelines recommend use of SGLT2 inhibitors (SGLTi) and glucagon-like-1 receptor agonists (GLP-1 RAs), but these are often not

being used. Some of the questions his group is considering include:
    - Should these patients be scheduled for follow up sooner, or more often?
    - Would these patients benefit from visits with other types of providers?
- Dr. Stebbins (UCSF): Her focus is on an accountable care organization (ACO) population that is doing well with blood pressure control except in the African-American population. Due to this racial disparity in hypertension control, she has been focused on how to reach out and engage patients with people in their community who they trust, as exemplified by the barbershop study in Los Angeles County. Currently, they don't trust their providers and don't go to their follow-up appointments.
- Dr. Liu (Santa Clara Family Health Plan): Quality integration throughout the health plan is a current focus. Her group is also looking for feasible ideas for innovation and a comprehensive strategy. One area being reviewed is maximizing medical pharmacy.
- Dr. Dryjanski (Southern California Permanente Medical Group): His focus is currently on biosimilars, especially in specialty areas like rheumatology and gastroenterology.
- Dr. Young (Kaiser Permanente, Northern California): Her topics of focus include biologics, immunotherapy such as chimeric antigen receptor (CAR) T-Cell therapy, looking at drug utilization in the hospital setting (such as intravenous acetaminophen), and using predictive modeling for adverse events.
- Dr. Leung (Partnership HealthPlan of California): He is interested in specialty pharmacy and how spending can be optimized in that setting. He is also focus on quality and trying to align activities across the organization.
- Dr. Blatt (Central California Alliance for Health): His group is currently focused on the integration of 6,500 pharmacy members through the California Children's Services (CCS) Program. He is also involved with formulary review, including re-evaluating the steps and removing prior authorization (PA) requirements for certain specialists, in order to make sure the formulary is up to date with current guidelines. He also provides training for pharmacies on the PA process and use of emergency overrides and has a train-the-trainer program with pharmacy technicians. His other areas of interest include an academic detailing program for naloxone, a naloxone performance improvement project in Merced, and offering medication lock boxes as a pharmacy benefit.
- Dr. Paulson (L.A. Care Health Plan): She is currently working on improving immunization rates, with a focus on the pneumococcal vaccine in order to decrease hospitalizations during flu season. She is also focused on improvements in the use of technology, including e-prescribing incentives and health information data exchange.
- Dr. Chan (Independent Consultant): He is also focused on specialty medications, as well as polypharmacy. He found many patients using 15-18 medications for no clear reason. He is considering a quality program to investigate this and evaluate why some patients need so many medications, while also understanding there is no one size fits all approach. He would like to focus on ways that we could optimize the patient's medications.
- Dr. Khurana (Aetna): Her group found that a fraction of utilizers are responsible for a large percentage of pharmacy cost. They are currently reviewing medication spending for these patients and whether the money is being spent wisely. In addition to a focus on opioids and benzodiazepines, she is interested in utilization of gabapentin and if patient indications for taking this drug are medically appropriate.
- Dr. Jai (Inland Empire Health Plan): His group is focused on population health and longitudinal disease management, as the patient population increasingly needs to manage the course of diseases over time. He is also looking from a payer perspective to understand the value of pharmacy services to providers and how to maximize outcomes. Some ideas include using contracts to incorporated value-based care, with a need to attach metrics and outcomes to each project. His group continues to look longitudinally at medication use and make sure drugs are being appropriately prescribed.
- Dr. Stafford (Stanford University): He would like to figure out a way to maximize the benefit of the group and to develop synergies with a focus on population health and management of chronic diseases. His other topics of interest include a focus on cost and value, which can often be made difficult due to contracting, developing a whole patient approach, reviewing early refills and potential accumulation of medications, and learning more about patient anxiety surrounding medications.

- Dr. Chau (San Francisco Health Plan): Her areas of focus include chronic disease state management, medication therapy management, increasing adherence, and new treatment options to address pain, including a recent expansion to include acupuncture as a covered benefit. She is also evaluating the concurrent use of opioids and benzodiazepines and her plan sponsors an annual Pain Day for providers, in order to keep providers informed of current guidelines for how to manage pain. She is also evaluating how providers cancel prescriptions so they are not inadvertently filled after discontinuation.

Dr. Wong suggested that Ms. Chan collate the priorities described and send out the list of topics to the Board to review and to vote for their top three. A motion was made to summarize the list of topics into a survey and send to the Board for voting.

AYE: Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Albertson, Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to develop and send a survey to the Global DUR Board that includes all suggested DUR priorities by the Board – in order to vote on the top three DUR priorities – will be submitted to DHCS.

h. Prospective DUR: Fee-for-Service

i. Review of DUR Alerts for New GCNs in 1Q2018 (January – March 2018): At each Board meeting, a list of new GCN additions with prospective DUR alerts turned on other than ER and DD will be provided to the Board for review. At this meeting, the Board reviewed the alert profiles of the following GCNs:

- GCN #078045: NIVOLUMAB – Drug-Pregnancy (PG)
- GCN #078038: METHYLPHENIDATE HCL – High Dose (HD), Low Dose (LD)
- GCN #072354: GEMCITABINE HCL – Drug-Pregnancy (PG)
- GCN #078005: BORTEZOMIB – Drug-Pregnancy (PG)
- GCN #078062: DAPAGLIFLOZIN/METFORMIN HCL – Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
- GCN #078093: APIXABAN – Late Refill (LR)
- GCN #078091: DIPHENHYD/PE/ACETAMINOPHEN/GG – Ingredient Duplication (ID), High Dose (HD)
- GCN #078146: BICTEGRAV/EMTRICIT/TENOFOV ALA – Ingredient Duplication (ID)
- GCNs #078051, #078052, #078053, and #078054: ERTUGLIFLOZIN/METFORMIN – Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
- GCNs #078180, #078181, #078182, #078183, and #078192: IBRUTINIB – Drug-Pregnancy (PG)
- GCN #078147: DICLOFENAC SODIUM/MENTHOL – Drug Allergy (DA), Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078145: EFAVIRENZ/LAMIVU/TENOFOV DISOP – Drug-Pregnancy (PG), Ingredient Duplication (ID)

- A motion was made – and seconded – to accept these alert profile recommendations. There was no further discussion. The motion was carried.

AYE: Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Albertson, Dhanvanthari, Walker, Zuniga

ii. Therapeutic Duplication (TD) Alert: Levonogestrel – Ms. Fingado reported that effective March 6, 2018, the TD alert for all GCNs for levonorgestrel emergency contraception has been turned off because paid claims for levonorgestrel emergency contraception were generating TD alerts when submitted at the same time as a claim for contraceptive pills for birth control.

iii. Ingredient Duplication (ID) Alert: LITHIUM (Update) – Effective February 20, 2018 all GCNs for non-300 mg formulations of lithium had the ID alert turned off, per DHCS and Global DUR Board recommendations. However, Ms. Fingado reported that a review of all March 2018 prospective DUR alerts showed some formulations of lithium were still generating ID alerts, even when neither drug was a 300 mg formulation. Ms. Fingado stated that Conduent was investigating the issue and just informed the DUR team yesterday that the problem should be fixed and the ID alert should be working as intended. Ms. Fingado noted that another review will be conducted using the June 2018 prospective DUR data and the Board will receive another status update on this matter at the next Board meeting in September.

iv. Drug-Pregnancy (PG) Alert: Update – Ms. Fingado reported that per DHCS and Board recommendation, the PG alert was turned off for 26 drugs because their First Databank (FDB) severity level indicated they were not PG category D, X, or severity level 1. However, on April 28, 2018, DHCS became aware of discrepancies between the FDA and FDB classifications of PG severity for nine of the 26 drugs. At that time, DHCS issued an amendment of the previous recommendation, keeping the PG alert on for all 26 drugs until a further review into the FDB classification system can be completed. Updates will be provided to the Board as we learn more.

i. DUR Educational Outreach to Providers: Fee-for-Service

i. Proposal: NRT in the Pharmacy – Ms. Fingado proposed an educational letter to pharmacies regarding pharmacist furnishing of NRT. The three earning objectives for this educational letter are as follows:

- To inform pharmacy directors about recent legislation that allows pharmacist reimbursement as providers for selected pharmacy services, including providing tobacco cessation counseling and furnishing NRT
- To encourage pharmacy directors to support their pharmacists in completing the minimum of two hours of an approved continuing education program specific to smoking cessation therapy and nicotine replacement therapy and enrolling as an ordering, referring, and prescribing (ORP) provider in Medi-Cal
- To promote tobacco cessation counseling and furnishing of NRT to eligible Medi-Cal beneficiaries

A total of 200 California pharmacies will be selected based on geography and claim volume, with pharmacy locations in one of the ten counties with the highest adult smoking rates (Del Norte, Humboldt, Lake, Lassen, Modoc, Plumas, Shasta, Siskiyou, Trinity, and Yuba). The letter will include the overall volume of Medi-Cal paid claims and total Medi-Cal utilizing beneficiaries. The NRT bulletin and pharmacy survey will be included. The primary outcome will be the number of paid claims for pharmacist-furnished NRT within the 12-month period following the mailing of the intervention letter. Secondary outcomes include the total number of pharmacists in each of the 10 counties successfully completing a DHCS 6219 application (within 12 months of mailing) and the total number of pharmacists in each of the 10 counties furnishing NRT (within 12 months of mailing). Ms. Fingado stated that this could be considered as a pilot mailing, and if it was well received could be repeated in additional counties.

A motion was made to complete an educational outreach to pharmacies regarding pharmacist furnishing of nicotine replacement therapy medications. There was no further discussion. The motion passed.

AYE: Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Albertson, Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to complete an educational outreach to pharmacies regarding pharmacist furnishing of nicotine replacement therapy medications will be submitted to DHCS.

ii. Outcomes: Triptans – Ms. Fingado reported that the migraine quality-of-care bulletin was published in 2013, before the onset of letters to providers and pharmacies and the 2017 biennial review found several domains related to migraine quality-of-care had declined since 2013. As a result, the Board recommended updating the original bulletin and sending out provider letters aimed at high users of triptan medications. The study population included fee-for-service beneficiaries that were continuously eligible between January 1, 2017, and December 31, 2017 (the measurement year) and were high users of triptan medications (defined as greater than 12 doses per month, for each month during the measurement year) and had fewer than seven paid claims for migraine preventive medications during the measurement year.

Ms. Fingado stated that only eight patients were identified that met the inclusion criteria (a total of 12 prescribers were identified for the mailing). While the letters were mailed on March 13, 2018 (5 letters were re-mailed with updated addresses on April 11, 2018), primary and secondary outcomes will not be calculated due to small sample size. Ms. Fingado described the lessons learned from this mailing, including how expanding the definition of a migraine preventive medication to include medications beyond those with the highest levels of evidence for preventing episodic migraines greatly increased the percentage of high users of triptan medications with ≥ 7 preventive medications during the measurement year and how there is now a process in place for updating future DUR educational bulletins, as needed.

iii. Updated Outcomes: Asthma 2017 – Ms. Fingado reported on the final outcomes of the second asthma mailing, which was sent on February 17, 2017. The objective for this mailing was to improve the quality of asthma care in the Medi-Cal fee-for- service (FFS) population.

- The final undeliverable rate was 5%, and includes those prescribers with both mailings returned as undeliverable and those prescribers who had the first mailing returned undeliverable and did not have an additional address for the re-mailing.
- The final response rate was 17%.

A total of 445 Medi-Cal FFS beneficiaries (out of 528; 84%) remained continuously eligible in the Medi-Cal FFS program between through March 1, 2017, and February 28, 2018.

- Primary outcome (within 12 months following the mailing):
  - 16% of the 445 beneficiaries (n=73) had an outpatient visit in which asthma was one of the listed diagnoses
- Secondary outcomes (within 12 months following the mailing):
  - 13% of beneficiaries had an AMR ≥ 0.50 (among the 354 beneficiaries still taking medication for asthma), up from 0%
  - The mean net change in AMR by individual utilizing beneficiaries (among the 354 beneficiaries still taking any medication for asthma) was 0.06 (0.16 to 0.22).
  - 10% (n=43) of beneficiaries had an emergency department visit where the primary diagnosis was asthma
  - 1% (n=3) had an inpatient hospitalization where the primary diagnosis is asthma

Ms. Fingado reported on three lessons learned during this mailing: 1) the greater sample size allowed for more robust analysis; 2) the program was able to make a

greater impact (more letters) but providing less detailed information; and 3) the streamlined variables allowed for a more efficient mailing (mailing these 661 letters took less time than the original 42 letters in the first asthma mailing).

iv. Updated Outcomes: Buprenorphine – Ms. Fingado reported on the final outcomes of the buprenorphine mailing. The objectives for this mailing were: 1) to inform providers that buprenorphine use among Medi-Cal fee- for-service beneficiaries is associated with high adherence rates and decreased concomitant use of high-risk medications, including other opioids; 2) to increase the number of Medi-Cal patients receiving treatment with buprenorphine; and 3) to increase the number of Medi-Cal providers able to provide buprenorphine treatment.

A total of 445 Medi-Cal FFS beneficiaries (out of 528; 84%) remained continuously eligible in the Medi-Cal FFS program between through March 1, 2017, and February 28, 2018.

- Primary outcome (within 12 months following the mailing):
  - There was a 5% increase in the number of patients (all of Medi-Cal) with paid claims for buprenorphine among providers who received the mailing (went from 8,618 to 9,051 paid claims).
- Secondary outcomes (within 12 months following the mailing):
  - Five providers out of the top 100 (5%) prescribers of opioids received a waiver, and prescribed buprenorphine to a Medi-Cal beneficiary (n=19)
  - The percentage change of total opioid prescribing in the Medi-Cal fee-for-service population, by individual provider among providers contacted decreased by 30% (compared with a 24% decrease by the next 100 providers).

Based on these results, a motion was made to repeat this educational outreach letter. Dr. Mowers asked if information on naloxone could be included in the mailing to the top prescribers of opioids (by volume). Ms. Fingado agreed this was important and would be included. There was no further discussion. The motion passed.

AYE: Blatt, Chan, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Young
NAY: None
ABSTAIN: None
ABSENT: Albertson, Dhanvanthari, Walker, Zuniga

ACTION ITEM: The DUR Board recommendation to repeat the educational outreach to top prescribers of opioids regarding the buprenorphine waiver will be submitted to DHCS.

j. Pharmacy Update presented by Pauline Chan

i. CMS Annual Report FFY 2018 – Ms. Chan reported that the CMS questionnaire for FFY 2018 has been finalized within the past week and has been sent to the plans.

ii. DHCS Quality Strategy 2018 – Ms. Chan shared the DHCS Strategy for Quality Improvement in Health Care, which was released in March 2018. Ms. Chan stated this in an annual blueprint describing the goals, priorities, guiding principles, and specific programs within DHCS. She reported that the *Quality Strategy* aligns with other state QI initiatives and the National Strategy for Quality Improvement in Health Care. She noted that beginning in 2018, the *Quality Strategy* is going to be incorporated into the DHCS Medicaid Managed Care Quality Strategy Report. Ms. Chan noted the *Quality Strategy* is anchored by the following three linked goals:

1) Improve the health of all Californians;
2) Enhance quality, including the patient care experience, in all DHCS programs; and
3) Reduce the Department's per capita health care program costs.

	Ms. Chan also shared that the seven priorities of the *Quality Strategy* are to: 1) Improve patient safety; 2) Deliver effective, efficient, affordable care; 3) Engage persons and families in their health; 4) Enhance communication and coordination of care; 5) Advance prevention; 6) Foster healthy communities; and 7) Eliminate health disparities. iii. Medicaid Adult and Child Core Measures 2018 – Ms. Chan provided a summary of both the 2018 Core Set of Adult Health Care Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. iv. Prescription Drug Overdose Prevention Initiative – Ms. Chan described the statewide overarching strategy for the initiative, which includes safe prescribing, access to treatment, naloxone distribution, a public education campaign, and data informed and driven interventions. She provided the link to the Opioid Overdose Surveillance Dashboard, which includes data from multiple state agencies. Ms. Chan stated that the goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD. v. Academic Detailing Training Opportunity – Ms. Chan provided information on the following three resources focused on academic detailing and opioids: 1) Academic Detailing for Opioid Safety – an academic detailing webinar hosted by the California Healthcare Foundation 2) Opioid Stewardship and Chronic Pain - A guide for primary care providers. 3) Application: Academic Detailing for Opioid Stewardship – Applications are currently being accepted for academic detailing trainings in June 2018 in two Southern California locations. **k.** Recap of today's action items – Ms. Chan reported that today's action items for managed care health plans would be distributed as soon as possible. **l.** Looking ahead: Call for future meeting agenda – Ms. Chan requested future meeting agenda items to be shared with her on an ongoing basis.

5) PUBLIC COMMENTS	• None
6) CONSENT AGENDA	• The next Board meeting will be held from 9:30 a.m. to 3:00 p.m. on September 18, 2018, in the DHCS 1st Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.
7) ADJOURNMENT	• The meeting was adjourned at 3:04 p.m.

Action Items	**Ownership**
Post the minutes from the Board meeting held on March 6, 2018.	Amanda
The Board recommendation to discuss the automatic refill policy further at the September 2018 Global DUR Board meeting will be submitted to DHCS.	Pauline
The DUR Board recommendation to approve the FFY2017 DUR Annual Report to CMS will be submitted to DHCS.	Amanda/Pauline
The Board recommendation to develop a companion guide to the FFY2018 DUR Annual Report to CMS will be submitted to DHCS.	Pauline
The Board recommendation to review the priority order of DUR alerts will be submitted to DHCS.	Hannah/Amanda
The DUR Board recommendation to evaluate the drug utilization of CCS/GHPP enrollees will be submitted to DHCS.	Amanda

The DUR Board recommendation to reach out to other states regarding the implementation of pharmacist reimbursement policy will be submitted to DHCS.	Pauline
The DUR Board recommendation to complete an educational bulletin regarding pharmacist furnishing of naloxone will be submitted to DHCS.	Shal/Amanda
The DUR Board recommendation to develop and send a survey to the Global DUR Board that includes all suggested DUR priorities by the Board – in order to vote on the top three DUR priorities – will be submitted to DHCS.	Pauline
The DUR Board recommendation to complete an educational outreach to pharmacies regarding pharmacist furnishing of nicotine replacement therapy medications will be submitted to DHCS.	Amanda/Hannah/Shal
The DUR Board recommendation to repeat the educational outreach to top prescribers of opioids regarding the buprenorphine waiver will be submitted to DHCS.	Amanda/Hannah/Shal

Board Action Items – May 22, 2018

- Automatic Refill Policy
  - to be discussed today
- FFY2017 DUR Annual Report
  - submitted May 30, 2018
- FFY2018 DUR Annual Report Companion Guide/FAQ
  - to be discussed today
- Priority Order of Prospective DUR Alerts
  - to be discussed today
- CCS/GHPP Drug Utilization Review
  - to be discussed today

Board Action Items (continued)

- Pharmacy Reimbursement Policy
  - to be discussed today
- DUR Educational Bulletin: Naloxone
  - approved as topic; added to the queue
- 2018 – 2019 Board Priorities
  - to be discussed today
- DUR Educational Outreach to Pharmacies: NRT
  - to be discussed today
- DUR Educational Outreach to Providers: Opioids
  - to be discussed today

GLOBAL MEDI-CAL DRUG USE REVIEW BOARD
May 22, 2018 BOARD MEETING MCP ACTIONS

MCP: _____

Name of DUR representative: _____Attended meeting? Yes ___ No ___

Summary of Required Actions

I. Educational Bulletins: MCP to have a process for distribution of provider education programs and materials developed by Global DUR Board to their providers via established mechanisms.

Required dissemination of DUR educational bulletins and alerts		
Description	**Mechanism of dissemination**	**Date of Dissemination**
March 2018 Bulletin: In the Pharmacy: Pharmacists Furnishing Nicotine Replacement Products		

Summary of Global Medi-Cal DUR Board Activities
(not required to document on the Annual Report to CMS)

1. MCPs should have a general understanding of the DHCS Quality Strategy, with a focus on 2018 Core Sets of Adult and Child Health Care Quality Measures for Medicaid.

2. Academic Detailing for Opioid Safety Training opportunity for Health Plans is available. Contact the California Health Care Foundation (CHCF) for more details.

3. The FFY 2018 DUR Annual Report to CMS questionnaire has been finalized and was distributed to MCPs at the Pharmacy Directors Meeting on 4/18/18.

   Action:
   a. Establish a timeline for review and completion by April 1, 2019.
   b. Submit questions to DHCS promptly. DHCS is compiling a FAQ and companion guide to address common questions and will share with all MCPs by the September board meeting.

4. Best practices presentation: Pacific AIDS Education Training Center (Pacific-AETC) presented Pre-Exposure Prophylaxis (PrEP) Academic Detailing. The presenters encouraged health plans to contact them for training resources and other supports.

5. Best practices in smoking cessation

   Action:
   a. Review the California State Board of Pharmacy regulations for pharmacists to furnish nicotine replacement therapy (NRT) products.

Reminders

- MCPs are required to ensure representation and participation at Global Medi-Cal DUR Board meetings, either in-person or via webinar. Refer to the Global Medi-Cal DUR Board bylaws for the attendance requirements for Global Medi-Cal DUR Board members.

- MCPs are required to have a process for distribution of provider education programs and materials developed by Global Medi-Cal DUR Board to their providers.

Global Medi-Cal DUR Board Priorities

Andrew Wong, M.D.

Chair, Global Medi-Cal DUR Board

Global Medi-Cal DUR Board Priorities Survey Results (n = 12)

- Top 3 by total votes:
  1) Medication Use Optimization: Reduce Polypharmacy and Eliminate Unnecessary Drugs
  2) Specialty Pharmacy: Cost Effectiveness and Quality of Care
  3) Appropriate Use of Medication in High Utilizers and Super Utilizers

- Clear delineation (five topics tied for 4th place)

Global Medi-Cal DUR Board Priorities Survey Results (cont.)

- 4th place topics (all received two votes):
  1) Fostering Closer Collaboration between Medical and Pharmacy Services for Optimal Care
  2) Specialty Drugs and Biosimilar Drugs
  3) Optimal Drug Use: Population Health and Longitudinal Studies
  4) Optimal Drug Use: Population Health and Chronic Disease Management
  5) Value-Based Purchasing

Priority Actions

Medi-Cal DUR

Reduce Polypharmacy and Eliminate Unnecessary Drugs

- Is there a group or groups of drugs or combinations prone to polypharmacy?
- Are there existing measures or standards to use?
- What information and data do we need to collect?
- Who are the key stakeholders/target audience?
  - Prescribers/physicians
  - Pharmacies/pharmacists
  - Patients/beneficiaries
  - Other key stakeholders
- What high-impact educational interventions should we choose?
- What is the time line to complete?

Specialty Pharmacy: Cost Effectiveness and Quality of Care

- Is there a specific group or groups of specialty pharmacy drugs that should be included?
- Are there existing measures or standards to use on quality of care? Cost effectiveness?
- What information and data do we need to collect?
- Who are the key stakeholders/target audience?
  - Prescribers/physicians
  - Pharmacies/pharmacists
  - Patients/beneficiaries
  - Other key stakeholders
- What high impact educational interventions should we choose?
- What is the time line to complete?

Appropriate Use of Medication in High Utilizers and Super Utilizers

- Are there existing measures or standards to define high utilizers and/or super utilizers? What about appropriate use?
- What information and data do we need to collect?
- Who are the key stakeholders/target audience?
  - Prescribers/physicians
  - Pharmacies/pharmacists
  - Patients/beneficiaries
  - Other key stakeholders
- What high-impact educational interventions should we choose?
- What is the time line to complete?

Medi-Cal DUR

Next Steps

- Summarize today's discussion and report at November 2018 Board meeting
- Incorporate into Board Goals for 2019

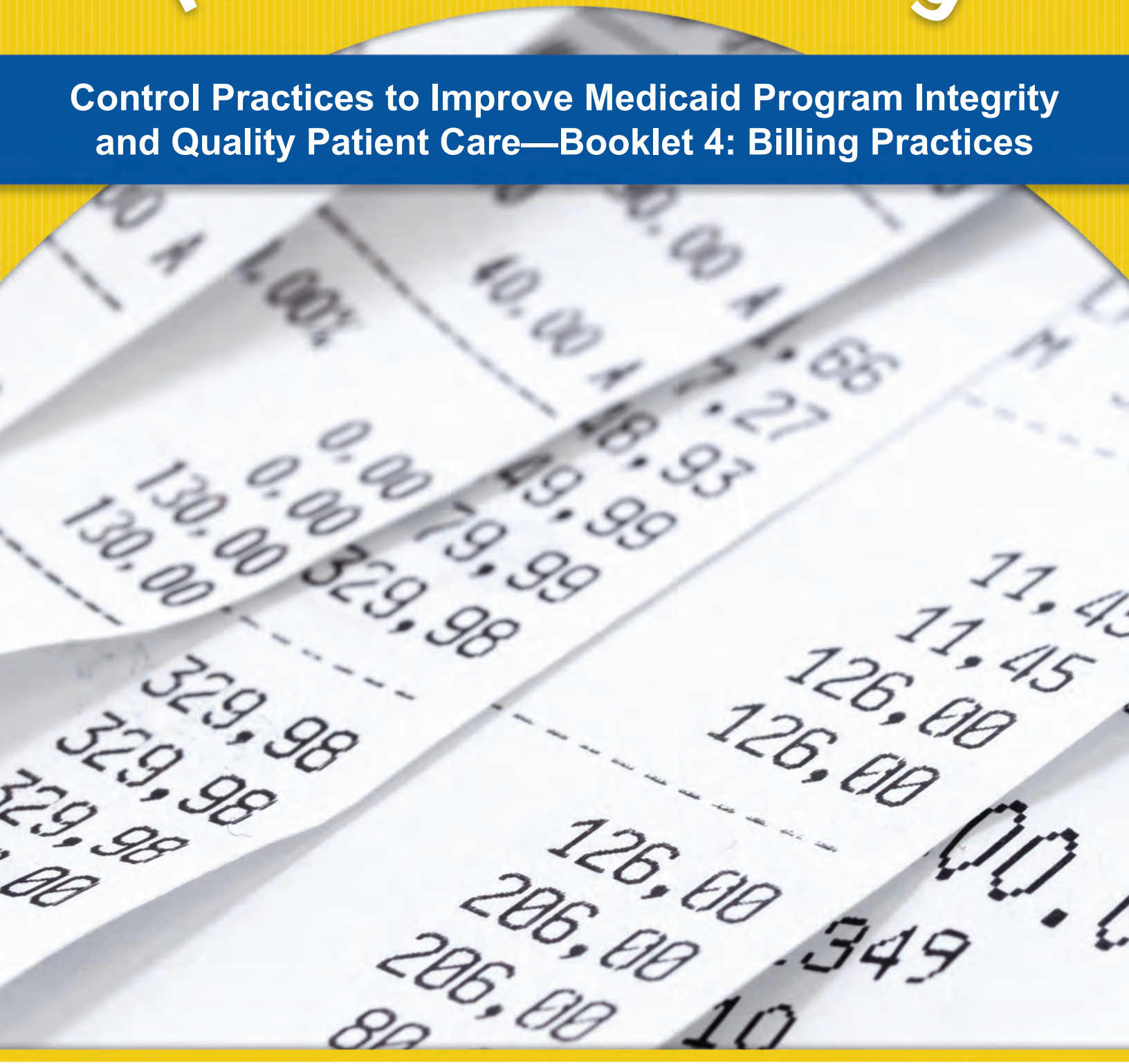
Auto-Refill

- DHCS is considering a requirement that pharmacies auto-refill only upon a patient's consent or request.
- Pharmacies may perform patient outreach to initiate refills in attempts to improve medication adherence and clinical outcomes.
- Pharmacies do not offer financial incentives to influence beneficiary decisions about when or where to fill prescriptions paid by a federally funded program.

Reference: CMS Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality Patient Care – Booklet 4: Billing Practices, page 6-8.

Pharmacy Self-Auditing

Control Practices to Improve Medicaid Program Integrity and Quality Patient Care—Booklet 4: Billing Practices



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

This booklet is the fourth in a four-booklet series that discusses areas of pharmacy practice prone to triggering audits that pharmacy health care professionals should examine. This booklet focuses on billing practices. The other booklets examine provider prescribing practices, controlled substance management, and invoices and claims management. The four booklets may be used together or independently as a self-audit to identify areas of risk as well as opportunity for improvement.

The Affordable Care Act of 2010 expanded Medicaid eligibility in States that have adopted Medicaid expansion. In such States, Americans who earn less than 138 percent of the Federal poverty level, $33,465 for a family of four in 2015, are eligible to enroll in Medicaid.[1] The National Health Expenditure Projections Forecast for 2014–2024 estimates Medicaid spending will grow by 5.9 percent on average annually from 2015 through 2024.[2]

The Medicaid expansion will impact Medicaid prescription drug utilization and expenditures. Private insurers lose about 1 to 1.5 percent of expenditures to fraud, while Medicaid may be closer to 10 to 15 percent.[3] Experts estimate another 20 to 30 percent of Medicaid dollars are lost to abuse or unnecessary services.[4]

According to the Kaiser Family Foundation, the Medicaid program paid 520 million prescription claims and spent $20.6 billion in total utilization expenditures in 2012, after recouping rebates.[5] The sheer volume of claims and expenditures requires Medicaid to protect itself from fraud, waste, and abuse.

Pharmacists' unique role in the health care system often allows for intervention before fraud, waste, or abuse occurs. Due to the high risk for improper payments, the Centers for Medicare & Medicaid Services (CMS) developed this toolkit to educate pharmacy providers on self-audit precautions related to invoice management, controlled substances management, proper billing practices, and proper prescribing practices. In addition, this toolkit addresses potential fraud, waste, and abuse related to pharmacy services and how to report them.

Pharmacy providers can identify areas of practice that require further scrutiny and can use these tools to educate staff about potential fraud, waste, and abuse.

Title 18 of the United States Code defines health care fraud as knowingly and willfully executing, or attempting to execute, a scheme to defraud a health care program or obtain money or property from a health care program under false pretenses.[6] Medicaid fraud artists intentionally submit false claims or misrepresent facts to obtain funds to which they are not entitled.[7]

Federal Medicaid regulations do not define waste. Waste is similar to fraud, but it is not usually associated with criminal actions.[8] Think of waste as overutilization or misuse of services. Abuse may encompass waste and includes any action that may cost the Medicaid system unnecessary dollars. Abuse may include improper payment for services, payment for services that fail to meet professionally recognized standards of care, or payment for services that are medically unnecessary.[9] Abuse includes reimbursement for claims to which the provider is not entitled, but health care professionals guilty of abuse do not intentionally misrepresent facts to obtain payment. Like waste, abuse is not usually associated with criminal actions.

The Federal False Claims Act (FCA) is an important tool for combating fraud. In general, the FCA imposes civil liability on people who knowingly submit a false or fraudulent claim or engage in various types of misconduct involving Federal government money or property. From January 2009 through the end of the 2013 fiscal year, the Justice Department used the FCA to recover more than $12.1 billion in health care fraud.[10]

A 2012 Office of Inspector General (OIG) report identified 2,637 retail pharmacies with questionable billing practices. The investigation found suspect pharmacies billed high dollar amounts per beneficiary, billed a high number of prescriptions per beneficiary, or billed for a high number of prescriptions per physician prescriber.[11] As a result, the OIG recommends CMS strengthen oversight of pharmacies and pharmacy audits.[12] Pharmacists can take the initiative to self-monitor practices within the pharmacy to prevent, identify, and correct potential fraud, waste, or abuse.

The audit process is a means of reviewing pharmacy practices to ensure staff members uphold operational procedures. State and Federal programs, such as Medicaid and Medicare Part D, State licensing boards, the

United States (U.S.) Drug Enforcement Administration (DEA), the U.S. Internal Revenue Service (IRS), and other third-party payers, conduct pharmacy audits. Through the pharmacy self-audit tool, pharmacy staff members can evaluate daily practices, pinpoint potential audit triggers, and proactively address vulnerabilities. Like any developing habit, a self-audit can become a part of daily, weekly, or monthly tasks.[13] Pharmacy managers can customize the pharmacy self-audit to ensure it addresses all pharmacy-specific compliance and operational procedures. When developing the blueprint for a customized pharmacy self-audit, consider the different forms of prescription drug fraud, waste, or abuse that may occur in the particular pharmacy setting, and focus on these vulnerabilities.

Fraud, waste, or abuse may occur as a result of billing miscalculations—quantity miscalculations or days' supply miscalculations. Fraud, waste, or abuse may also occur in the pharmacy as a result of inappropriate practices, including refill practices, overrides, partial fills, delivery documentation, or package size selection.

Pharmacists can help protect State Medicaid patients from harm and State Medicaid dollars from waste by educating staff members, providing billing job aids, and making sure all pharmacy staff members know what to do in the event a Medicaid billing error is discovered.

Billing Practices Self-Audit

This booklet (Booklet 4—Billing Practices) contains 15 of the 50 steps to conduct a pharmacy self-audit and examines common quantity and days' supply billing errors. In addition, inappropriate refill practices, overrides, partial fill procedures, and package size selection are discussed. A thorough review of these steps as they pertain to pharmacy practice will help pharmacies preserve State Medicaid program integrity and improve the quality of patient care for State Medicaid beneficiaries. Consider each step, answer the questions listed, and examine existing policies and procedures to identify any audit triggers related to billing practices.

The three additional booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit (Booklet 1—Prescribing Practices, Booklet 2—Controlled Substances Management, and Booklet 3—Invoice Management) contain the remaining steps, with audit questions and detailed information regarding each step. The steps in the four booklets correspond to the steps in the document titled "Pharmacy Auditing and Dispensing: The Self-Audit Control Practices to Improve Medicaid Program Integrity and Quality Patient Care Checklist."

Pharmacists represent a unique line of defense against fraud, waste, and abuse. Pharmacists may help uncover unnecessary costs to the Medicaid system by taking a close look at billing practices that include billing units, refill practices, overrides, partial fill procedures, package size selection, and proof of delivery documentation. If the following self-audit steps reveal potential overpayments, the self-audit toolkit explains what to do next.

36. Discuss billing procedures with staff to determine whether staff members correctly submit claims for drugs commonly submitted with improper billing units. Provide staff members with job aids associated with common types of quantity and/or days' supply miscalculations. The examples below are not comprehensive but suggest potential targets for job aids.
    - Oral products;
        - Anti-migraine agents;
        - Bowel preparations;
        - Multi-drug/multi-month packs; and
        - Osteoporosis agents.

- Other dosage forms;
  - Inhalers;
  - Ophthalmic products;
  - Topical products; and
  - Vaginal products.
- Injections; and
- Kits.

Reimbursements and rebates are two components of Medicaid prescription drug programs. When a pharmacy dispenses a prescription for a Medicaid beneficiary, the State Medicaid agency (SMA) reimburses the pharmacy, and then pharmaceutical manufacturers provide statutorily-defined rebates to the SMA for each unit of drug that was dispensed. SMAs reimburse pharmacies using the National Council for Prescription Drug Program's Billing Unit Standard (BUS), while pharmaceutical manufacturers submit rebates to SMAs using CMS unit of measure standards. Because SMAs must convert BUS units to CMS units, a pharmacy BUS claim submission error may also result in inaccurate pharmaceutical manufacturer rebates to the SMA.[14] If a pharmacy submits a claim for a drug with a National Drug Code (NDC) other than the NDC for the drug the pharmacy actually dispensed, the SMA may receive a rebate to which the State was not entitled or may not receive a rebate to which the State was entitled.

37. Review prescription requirements for non-controlled and controlled substances.[15, 16, 17]
    - ☐ Date of issuance;
    - ☐ Prescriber's signature;
    - ☐ Prescriber's authority to prescribe (For example: mid-level prescribers versus physicians; State regulations versus Federal days' supply regulations; and authorization to prescribe specific controlled drug schedules);
    - ☐ Drug name;
    - ☐ Drug strength;
    - ☐ Drug dosage form;
    - ☐ Quantity of drug prescribed;
    - ☐ Directions for use;
    - ☐ Number of refills authorized by the prescriber (if any);
    - ☐ "Brand name medically necessary" if no generic substitution is allowed;
    - ☐ If handwritten, controlled substance prescriptions must be written in ink or pencil that cannot be erased; and
    - ☐ Prescribers must manually sign controlled substance prescriptions on the date issued.
38. Ensure staff members are able to correctly calculate a day's supply for prescriptions.
    - ☐ Multiply the number of doses per day by the number of days of therapy to determine the correct quantity to dispense; and
    - ☐ Reverse-verify by dividing the quantity dispensed by the number of doses per day to determine the number of days' supply.

39. Talk to pharmacy staff members about prescriptions written for odd quantities.

    ☐ Reduce the quantity dispensed to correspond to a number of days equal to or less than the plan-imposed maximum if the days' supply calculated by dividing the quantity dispensed by the number of doses per day exceeds the plan-imposed maximum allowable days' supply.

    Upon review of the prescription, pharmacists may see quantities and days' supplies that do not align. Inaccurate claim submission of these types of discrepancies may lead to negative audit findings. For example, if the prescription presented is written for 100 tablets for a 30 days' supply, but the sig code states the drug should be taken three times daily, the pharmacist must either adjust the dispensed quantity to 90 tablets for 30 days or adjust the days' supply to 33.

40. Talk to pharmacy staff members about prescriptions written for doses that exceed Food and Drug Administration (FDA) labeling.

    ☐ Examine high doses with scrutiny;

    ☐ Consult the FDA label;

    ☐ Contact the prescriber to verify the dose if it exceeds FDA recommendations; and

    ☐ Document all communication on the hard copy.

    Pharmacists should consult a drug reference if a prescribed dose appears in excess to determine if the dose prescribed is within FDA-labeled guidelines. The National Library of Medicine provides a free drug reference, DailyMed, accessible at https://dailymed.nlm.nih.gov/dailymed/index.cfm on the National Institutes of Health website. In addition, the FDA maintains a database of approved prescription labeling, Drugs@FDA, accessible at https://www.accessdata.fda.gov/scripts/cder/drugsatfda/ on the FDA website. Simply enter the name of the drug, navigate to the drug in question, and consider the dosage and administration guidelines listed in the product label. If the dose prescribed exceeds FDA-labeled recommendations, contact the prescriber to verify the dose. Document the verification on the hard copy. Include the diagnosis and the reason for override on the hard copy, if available.

41. Talk to pharmacy staff members about prescriptions that include the use-as-directed sig code for dispensed quantities more than one billing unit per month.

    ☐ Shampoos—Document frequency of use and size of area to be treated;

    ☐ Creams and ointments—Document frequency of use and size of area to be treated;

    ☐ Migraine medications—Document number of headaches treated per month;

    ☐ Insulin—Document exact regular dosage and maximum daily dosage for any sliding scale directions; and

    ☐ Diabetic syringes, test strips, or lancets—Document maximum use per day.

    Prescriptions that require more than one billing unit per month require more concise directions to accurately represent the days' supply. Contact the prescriber to determine the maximum daily dose and gather detailed information for each of these types of medications.

42. Talk to pharmacy staff members about refill practices.

    ☐ Do not push-bill or auto-refill without patient consent or request or when prohibited by State law;

    ☐ Do not refill and mail to patients without request or patient consent, and only perform patient outreach to initiate refills in attempts to improve medication adherence and clinical outcomes; and

- ☐ Do not use financial incentives to influence beneficiary decisions about when or where to fill prescriptions paid by a federally funded program.

Consider the risk for fraud, waste, or abuse if pharmacy staff members use inappropriate refill practices (for example: push-billing and auto-refills, refilling and mailing to patients without request or consent, or financial incentives). Push-billing occurs when pharmacy providers auto-refill prescriptions without beneficiary consent or request. The U.S. Department of Justice's Civil Fraud Division investigated auto-refill practices at a major retail chain and alleged the chain auto-refilled and billed prescriptions without patient consent while pressuring pharmacists to meet 40 percent auto-refill enrollment goals.[18]

A suspect refill tactic targeted at Medicaid beneficiaries includes refilling prescriptions without a patient request and mailing the completed prescriptions to the beneficiary. Pharmacy providers should not auto-refill without a request from the beneficiary. Providers should only contact a beneficiary to solicit requests for medication refills if the pharmacy provider has assessed the beneficiary's prescription history and the patient outreach is an attempt to improve the patient's medication adherence and clinical outcome.[19]

Financial incentives influence a patient's choice of pharmacy services for prescription refills and are prohibited. "Pharmacies are not allowed to improperly influence the decision-making of Medicare and Medicaid patients about where to fill prescriptions," said Special Agent in Charge Glenn R. Ferry for the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). "Pharmacy chains that manipulate patient choices in this way will be held accountable."[20] Financial incentives may include shopper loyalty programs that provide cents off gallons of gas or store credit, gift cards, or merchandise. Pharmacies should not waive copayments (if applicable) as an incentive for the patient to refill unneeded prescriptions. However, most States require a pharmacy to fill and dispense a Medicaid prescription, even if the beneficiary cannot pay the copayment or refuses to pay the copayment.

43. Consider possible patient-driven inappropriate refill practices.
    - ☐ Counsel patients if stockpiling is suspected;
    - ☐ Be aware of red flags that may indicate diversion and require further scrutiny; and

☐ If diversion is suspected, report concerns to the proper authorities.

Patients may stockpile—accumulate excessive and inappropriate amounts of prescription and over-the-counter drugs—for future use. Patient motives for stockpiling vary from fear of drug shortages or unexpected changes in prescription drug benefits to accumulation of drugs for the purpose of diversion or abuse.[21] Patients who stockpile may seek prescriptions from multiple prescribers, and unnecessarily accumulating drugs contributes to waste and abuse in the health care system.[22]

Drug diversion occurs when patients or other individuals divert drugs from the legal supply chain to an illegal supply chain for unlawful, often recreational, purposes. Drug diversion may occur anywhere along the supply chain: manufacturer, distributor, wholesaler, pharmacy, or end-user. Illicit drug distribution occurs in absence of a legal and medically necessary purpose. Costs of the prescription drug diversion epidemic to State Medicaid programs go far beyond the cost of the drug itself. Diversion results in additional costs to the SMA associated with emergency room visits, physician's visits, and rehabilitation services.[23] Ensure pharmacy staff members are familiar with ways patients commonly divert prescription drugs, including: card sharing, medication sharing, prescription pad theft, forged or altered prescriptions, doctor shopping, and theft.

Red flags that may indicate diversion include:

- The patient requests to pay cash when insurance coverage exists;
- One patient drops off or picks up multiple similar prescriptions for two or more patients;
- Similar or identical prescriptions originate from the same prescriber or practice for inordinately large quantities of medications typically diverted;
- Groups of patients drop off similar or identical prescriptions for commonly diverted medications, often written by a prescriber who practices in another city or county;
- The patient is unable to provide identification when requested;
- The diagnosis given by the patient does not match the diagnosis given by the prescriber;
- The prescriber is unable or unwilling to give a diagnosis or provides the same diagnosis for all patients, such as back pain or degenerative disc disease;
- The prescriber is unavailable to speak directly with the pharmacist, will not return calls, or takes an unusual amount of time to respond to the pharmacist;
- The prescriber has not committed his or her DEA registration number to memory;
- The prescription does not contain all federally-mandated information; or
- The prescription does not comply with tamper-resistance industry standards or appears tampered with.

The DEA will hold accountable prescribers who issue prescriptions outside of legitimate medical use. The DEA also expects a pharmacist to exercise a corresponding responsibility to question prescriptions that do not appear to have been issued for a legitimate medical use.[24] Pharmacists should report their suspicions. Agencies that may be notified include:

- Local law enforcement;
- U.S. DEA;
- State Medicaid Fraud Control Unit; and
- State licensing board if a health care professional is involved.

Or contact:

U.S. Department of Health and Human Services, Office of Inspector General
ATTN: Hotline
P.O. Box 23489
Washington, DC 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: https://forms.oig.hhs.gov/hotlineoperations/

44. Talk to pharmacy staff members about overrides at the point of sale (POS).
    - ☐ Submit claims with vacation supply override codes only if the patient is on vacation; and
    - ☐ Submit claims with known prior authorization (PA) override codes only if the patient meets the PA criteria.

    Consider the risk for fraud, waste, or abuse if pharmacy staff members use override codes to adjudicate claims without appropriate substantiation. Inappropriate overrides for vacation supplies or PA at the POS are another potential source of risk for fraud. Recently, CareMed, a specialty pharmacy in New York, agreed to pay $9.5 million in fees to the Federal government and roughly $450,000 to the State of New York for falsifying PA information to process claims for Medicare and Medicaid beneficiaries. Pharmacy employees, with knowledge of the criteria at various insurance companies, would provide clinical information to the insurance representatives so the patient would "meet" the necessary requirements to have the medication covered.[25] Talk to staff members about when overrides are appropriate.

45. Talk to pharmacy staff members about prescription origin codes.
    - ☐ Do not alter prescription origin codes; and
    - ☐ Verify the prescriber DEA number and office telephone number for all controlled substance prescriptions received by telephone. If the caller or prescriber is unknown, confirm the contact information with a

secondary source. If the contact information differs, call the prescriber's office at a published telephone number to confirm the prescription.

Prescription Origin Codes[26]

Code	Appropriate Use
1	Written—Prescription is presented to the pharmacy on a paper prescription pad.
2	Telephone—Prescription is conveyed to the pharmacy verbally by telephone call, voicemail, or other electronically recorded verbal message.
3	Electronic—Prescription is transmitted to the pharmacy by the National Council for Prescription Drug Programs' SCRIPT Standard or Health Level 7 (HL7) Standard transactions.
4	Facsimile—Prescription is transmitted to the pharmacy by facsimile machine.
5	Pharmacy—A prescription origin code value of 5 is used when a pharmacy staff member must create a new prescription number from an existing prescription. This may occur due to prescription transfer between pharmacies, prescription transfer between pharmacies in the same parent organization, sale of prescription records from one pharmacy to another, or changes in pharmacy software requirements. A prescription code value of 5 is also appropriate when a pharmacist has prescriptive authority and dispenses a pharmacist-prescribed product, such as emergency contraceptives or Controlled Substances Act Schedule V cough preparations.

Consider the risk for fraud, waste, or abuse if pharmacy staff members adjudicate a claim with an origin code that does not apply. A prescription origin code identifies the method by which a pharmacy receives a prescription. It is important to note any changes made to the original prescription do not change the origin code.[27] Prescriptions received via phone may be particularly vulnerable given the capability to misrepresent a physician's office and provide a callback number that does not belong to the physician.[28] In one case

involving the New York Medicaid program, 69 of 172 prescriptions indicated as phoned-in from an initial sample audit were found to be improper.[29]

46. Talk to pharmacy staff members about product selection (dispense as written—DAW) codes.
    - ☐ Only use the DAW 1 product selection code when the prescriber has indicated product substitution is not allowed on the prescription; and
    - ☐ Only use the DAW 2 product selection code when the patient has requested to receive the brand name drug rather than the generic equivalent.

Prescription Selection Codes[30]

DAW Code	Appropriate Use
0	Appropriate when the prescriber indicates product substitution is allowed or when the prescriber does not include a product selection code on the written prescription. The pharmacy provider may dispense multi-source and single-source generic drugs or single-source brand name drugs using this product selection code.
1	Appropriate only when the prescriber indicates verbally or on the written prescription that substitution is not allowed— "substitution is not allowed," "dispense as written," or "brand name medically necessary." The pharmacy provider may only dispense the brand name version of the drug prescribed using this product selection code.
2	Appropriate only when the patient indicates he or she requests the brand name version of the drug prescribed. The pharmacy provider may dispense only the brand name version of the drug prescribed using this product selection code and may do so even though the prescriber did not indicate substitution is not allowed.
3	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug even though the generic drug was in stock.
4	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug because the generic drug was not in stock.
5	Appropriate if a generic drug is available, but the pharmacist opted to dispense the brand name drug and elected to be reimbursed for the generic drug.
6	Appropriate when an override DAW code is required.
7	Appropriate when substitution is not allowed because the brand name drug is required to be dispensed by State law. This may occur if State law requires drug testing of generic drugs that has not yet been completed.
8	Appropriate when the generic drug is not available. This may occur if the generic drug has been approved by the FDA but not yet manufactured and distributed.
9	Appropriate when the prescriber indicates product substitution is allowed, but the beneficiary's prescription drug plan requires the pharmacy to dispense the brand name product.[31] For example, the SMA may require the pharmacy to dispense the brand name product to meet the requirements of a statutorily defined manufacturer rebate agreement.

Consider the risk for fraud, waste, or abuse if pharmacy staff members adjudicate claims with inaccurate product selection codes. The DAW product selection code designation references the reason a particular brand is dispensed based upon direction from the prescriber.[32] Excessive use of certain DAW codes may raise red flags from an audit perspective, especially the use of DAW 1 on multi-source products. Review acceptable use of DAW 1 and DAW 9 codes with staff and emphasize appropriate documentation procedures. Proper documentation on prescriptions, especially those received via phone, is critical to withstand audit scrutiny and avoid fraudulent accusations of modifying the prescription to increase revenue. The phrases "brand name medically necessary" or "dispense as written" are needed in the cases of DAW 1 prescriptions. In some situations, SMAs may request a brand instead of generic substitution. In these instances with proper documentation, DAW 9 is appropriate.

47. Talk to pharmacy staff members about partial fill procedures.

- ☐ Adjudicate partial fills appropriately. Do not "owe" patients any drug quantity if the full quantity to be dispensed has already been billed;
- ☐ Only use the partial fill functionality of the billing system when unable to fill the full quantity to be dispensed;
- ☐ Do not bill the payer for the full amount of a partial refill; and
- ☐ Do not bill the payer for a second dispensing fee when completing a partial refill.

Consider the risk for fraud, waste, or abuse if pharmacy staff members bill for the entire prescribed quantity but dispense a partial supply while waiting for additional stock to be delivered. A partial fill occurs when a pharmacy does not dispense the total quantity of the medication indicated on the prescription. Potential fraud exists because the pharmacy may receive reimbursement to which it was not entitled. If the pharmacy bills and receives reimbursement for a complete fill and "owes" the beneficiary the remainder of the fill, the beneficiary may not pick up the owed portion, or the pharmacy may not be able to obtain additional supply of the medication. When the medication is returned to stock, the pharmacy inventory is inaccurate, and Medicaid has overpaid the pharmacy. This topic was the subject of an OIG investigation related to $25 million in overpayments by Medicare Part D for Schedule II prescriptions partial fill completions billed as refills.[33] In addition, pharmacies may create partial fill claims as a means to generate a second dispensing fee. As is

the case with other potential audit red flags, an excess of partial fills has the potential to trigger an audit. Implement a sound partial-fill protocol, including proper documentation, to avoid accusations of partially filling prescriptions in an effort to generate dispensing fee revenue.

48. Talk to pharmacy staff members about how they select package sizes when more than one size is available.
    - ☐ Select the smallest commercially available package size to address the prescription requirements;
    - ☐ Ensure the NDC dispensed matches the NDC billed, particularly for generic and compounded medications;
    - ☐ Adhere to State-specific Medicaid compound prescription billing requirements;
    - ☐ Bill accurate quantities of medications used in compounded medications; and
    - ☐ Confirm that commercially available equivalents do not exist and that the compounded medications are treating a medically necessary indication.

    Consider the risk for fraud, waste, or abuse if pharmacy staff members select a package size larger than is necessary. Areas that are particularly vulnerable to audit findings include topical preparations, reconstituted products, and compounds. Review with staff the importance of selecting the smallest commercially available package size, and in cases where this does not occur, document the reason for the larger package size on the prescription (for example: affected area for topical preparations). Staff must ensure the NDC dispensed matches the NDC billed. For compounded medication in particular, if a staff member bills for the entire contents of a package to create a compound when a smaller volume would have been adequate to create the compound, potential for fraud, waste, or abuse exists. In addition, pharmacy staff members may inappropriately flag non-compound products as compounds to increase revenue. A pharmacy owner in West Virginia recently pleaded guilty to defrauding Medicare and Medicaid for dispensing compounded generic medications and billing for the brand. Medicare and West Virginia Medicaid will recover $1.1 million from a settlement with the pharmacy.[34] Review compound prescription billing procedures with staff to ensure the correct package size and NDC are selected and billed appropriately and to prevent future audit recovery.

49. Talk to pharmacy staff members about how they document beneficiary receipt of prescriptions.
    - ☐ Always obtain signatures from patients or their agents at the time of prescription pickup.

    Consider the risk for fraud, waste, or abuse if pharmacy staff members do not document proof of delivery. Routine examination of signature logs is worthwhile to prepare for potential audits or to uncover fraud in the form of forged signatures. The potential for fraud exists when no records demonstrate proof of delivery because pharmacy employees may forge a beneficiary's signature for a prescription that never reaches the beneficiary.[35]

50. If a Medicaid overpayment is identified, take one of the following steps:
    - ☐ Reverse any claim within the last year;
    - ☐ Send a check and an explanation for any older claim; or
    - ☐ Self-disclose the overpayments to your SMA or the OIG.

    Pharmacies must report the overpayment within 60 days from the date the overpayment is identified.[36] Overpayments usually include the following situations:[37]

    - At the time of the service, the individual receiving the service was not eligible for Medicare or Medicaid;
    - Medicare or Medicaid mistakenly paid as primary where another third-party payer was properly primary;
    - The payment amount was miscalculated and excessive;

- The service did not fall within one of the statutory benefits or was subject to a statutory exclusion; or
- The service was not medically necessary.

The FCA contains a whistleblower provision allowing an individual, known as a "relator," to file a lawsuit on behalf of the Federal government against a person or business based on evidence of fraud against Federal programs or contracts. The whistleblower is entitled to a portion of any monies recovered.[38] The FCA includes a treble damages provision (a tripling of actual and compensatory damage) for persons who have "actual knowledge, deliberate ignorance of the truth or falsity of the information, or reckless disregard of the truth or falsity of the information."[39] In addition, persons may be found to have violated the FCA in reverse—not by receiving money to which the person is not entitled, but by avoiding payment of monies due the Federal government.[40] In addition, a pharmacy may be terminated as a Medicaid provider for cause because the pharmacy has engaged in fraud for abusing billing privileges (for example: billing for services that were not provided or failing to repay a Medicaid overpayment).[41] Identifying and reporting overpayments in a timely manner will prevent negative consequences and offers the pharmacy the opportunity to provide staff training to prevent future overpayments.

Conclusion

CMS is committed to educating pharmacy providers about potential fraud, waste, and abuse related to pharmacy services. The four Pharmacy Self-Auditing booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit provide self-audit steps to identify potential audit triggers in a pharmacy practice. The booklets address areas prone to potential fraud, waste, and abuse related to pharmacy services, and provide instruction on how to report suspected fraud, waste, and abuse. Pharmacy providers can use audit findings to identify areas of practice that require further scrutiny as well as use these tools to educate pharmacy personnel about potential fraud, waste, and abuse.

This booklet discusses how evaluating billing practices can be incorporated into a pharmacy self-audit. The booklet contains 15 of the 50 steps to conduct a pharmacy self-audit and examines common quantity and days' supply billing errors. In addition, inappropriate refill practices, overrides, partial fill procedures, and package size selection are discussed. A thorough review of these steps as they pertain to pharmacy practice will help pharmacies preserve State Medicaid program integrity and improve the quality of patient care for State Medicaid beneficiaries.

To review any of the three additional booklets in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit (Booklet 1—Prescribing Practices, Booklet 2—Controlled Substances Management, and Booklet 3—Invoice Management), with audit questions and detailed information regarding each step, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website. The steps in the four booklets correspond to the steps in the document titled "Pharmacy Auditing and Dispensing: The Self-Audit Control Practices to Improve Medicaid Program Integrity and Quality Patient Care Checklist."

To see the electronic version of this booklet and the other products included in the "Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

1 Centers for Medicare & Medicaid Services. (n.d.). Medicaid & CHIP. Medicaid Expansion & What it Means for You. Retrieved March 18, 2015, from https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

2 Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2014-2024. Retrieved October 1, 2015, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2014.pdf

3 Matthews, M. (2012, May 31). Medicare and Medicaid Fraud Is Costing Taxpayers Billions. Forbes. Retrieved March 18, 2015, from http://www.forbes.com/sites/merrillmatthews/2012/05/31/medicare-and-medicaid-fraud-is-costing-taxpayers-billions/

4 U.S. House of Representatives. Committee on Oversight and Government Reform. (2012, April 25). Uncovering Waste, Fraud, and Abuse in the Medicaid Program. Retrieved March 18, 2015, from https://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf

5 Bruen, B. & Young, K. (2014, December 10). What Drives Spending and Utilization on Medicaid Drug Benefits in States? The Henry J. Kaiser Family Foundation. Retrieved March 18, 2015, from http://kff.org/report-section/what-drives-spending-and-utilization-on-medicaid-drug-benefits-in-states-issue-brief/

6 Health Care Fraud, 18 U.S.C. § 1347 (2010). Retrieved March 17, 2015, from http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap63-sec1347.pdf

7 Definitions, 42 C.F.R. § 455.2. (2011). Retrieved March 17, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?SID=079196713a1d27e688ca77d9927a9f4a&node=pt42.4.455&rgn=div5#se42.4.455_12

8 National Association of Medicaid Directors. (2012, March). Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in High-Value Tools. Retrieved March 17, 2015, from http://medicaiddirectors.org/wp-content/uploads/2015/08/namd_medicaid_pi_position_paper_final_120319.pdf

9 National Association of Medicaid Directors. (2012, March). Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in High-Value Tools. Retrieved March 17, 2015, from http://medicaiddirectors.org/wp-content/uploads/2015/08/namd_medicaid_pi_position_paper_final_120319.pdf

10 Staman, J. (2014, September 8). Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview. Congressional Research Service. Retrieved March 19, 2015, from http://fas.org/sgp/crs/misc/RS22743.pdf

11 U.S. Department of Health and Human Services. Office of Inspector General. (2012, May). Retail Pharmacies With Questionable Part D Billing. Retrieved March 18, 2015, from https://oig.hhs.gov/oei/reports/oei-02-09-00600.pdf

12 U.S. Department of Health and Human Services. Office of Inspector General. (2012, May). Retail Pharmacies With Questionable Part D Billing. Retrieved March 18, 2015, from https://oig.hhs.gov/oei/reports/oei-02-09-00600.pdf

13 Baird, J. (2011, January). Self-Audits: The 'Canary in the Mine Shaft' for Avoiding Recoupments. Pharmacy Law. Retrieved March 17, 2015, from http://www.americaspharmacist.net/issues/APJAN11-PharmacyLaw.pdf

14 U.S. Department of Health and Human Services. Office of Inspector General. (2007, November). Unit of Measure Inconsistencies in the Medicaid Prescription Drug Program. Retrieved March 24, 2015, from https://oig.hhs.gov/oei/reports/oei-05-07-00050.pdf

15 Administrative Rules of Montana. (2011, June 24). Prescription Requirements, Rule 24.174.510. Retrieved March 30, 2015, from http://www.mtrules.org/gateway/ruleno.asp?RN=24.174.510

16 Administrative Rules of North Dakota. (2012, October). Requirements of a Prescription Order for Noncontrolled Drugs, Chapter 61-04-06-02. Retrieved March 30, 2015, from http://www.legis.nd.gov/information/acdata/pdf/61-04-06.pdf?20150330074620

17 21 C.F.R. § 1306.05. Retrieved April 15, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=21%3A9.0.1.1.7#se21.9.1306_105

18 Lazarus, D. (2012, October 19). U.S. Investigating CVS Prescription Refills. Los Angeles Times. Retrieved March 17, 2015, from http://articles.latimes.com/2012/oct/19/business/la-fi-lazarus-20121019

19 Minnesota Department of Human Services. (2014, May 6). Pharmacy Services: Automatic Refills. Retrieved March 23, 2015, from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008992#P193_17710

20 U.S. Department of Justice. (2014, December 3). Rite Aid Corporation Pays $2.99 Million for Alleged Use of Gift Cards to Induce Medicare and Medicaid Business. Retrieved March 16, 2015, from http://www.justice.gov/opa/pr/rite-aid-corporation-pays-299-million-alleged-use-gift-cards-induce-medicare-and-medicaid

21 AMCP. (n.d.). The Academy of Managed Care Pharmacy's Concepts in Managed Care Pharmacy: Medication Stockpiling. Retrieved March 23, 2015, from http://amcp.org/WorkArea/DownloadAsset.aspx?id=9792

22 AMCP. (n.d.). The Academy of Managed Care Pharmacy's Concepts in Managed Care Pharmacy: Medication Stockpiling. Retrieved March 23, 2015, from http://amcp.org/WorkArea/DownloadAsset.aspx?id=9792

23 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2012, January). Drug Diversion in the Medicaid Program: State Strategies for Reducing Prescription Drug Diversion in Medicaid. Retrieved March 23, 2015, from https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaidintegrityprogram/downloads/drugdiversion.pdf

24 U.S. Department of Justice. Drug Enforcement Administration. Office of Diversion Control. (n.d.). Section IX – Valid Prescription Requirements. Retrieved May 7, 2015, from http://www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_content.htm#9

25 The United States Attorney's Office. Southern District of New York. (2014, October 9). Manhattan U.S. Attorney Settles Civil Fraud Claims Against Caremed [sic] Pharmaceutical Services for Engaging in Fraudulent Conduct. Retrieved March 17, 2015, from http://www.justice.gov/usao/nys/pressreleases/October14/CareMedSettlementPR.php

26 National Council for Prescription Drug Programs. (2013, November). Telecommunication Version D and Above Questions, Answers and Editorial Updates (p. 22). Retrieved March 24, 2015, from http://www.ncpdp.org/members/pdf/versiond.editorial.pdf

27 National Council for Prescription Drug Programs. (2013, November). Telecommunication Version D and Above Questions, Answers and Editorial Updates (p. 22). Retrieved March 24, 2015, from http://www.ncpdp.org/members/pdf/versiond.editorial.pdf

28 U.S. Department of Justice. Drug Enforcement Administration. Office of Diversion Control. (2000, February). A Pharmacist's Guide to Prescription Fraud. Retrieved March 24, 2015, from http://www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm

29 New York State Office of the State Comptroller Thomas P. DiNapoli. Division of State Government Accountability. (2013, August). Payments for Fraudulent and Improper Claims Submitted by Davis Ethical Pharmacy. Retrieved March 24, 2015, from http://osc.state.ny.us/audits/allaudits/093013/12s11.pdf

30 University of Kansas School of Pharmacy. (n.d.). Dispensing (DAW) Codes. Retrieved March 24, 2015, from http://pskills.pharm.ku.edu/rxgenerator/tp/DAWCodes.html

31 National Council for Prescription Drug Programs. (2013, November). Telecommunication Version D and Above Questions, Answers and Editorial Updates (p. 19). Retrieved March 24, 2015, from http://www.ncpdp.org/members/pdf/versiond.editorial.pdf

32 National Council for Prescription Drug Programs. (2005, October 4). NCPDP Reference Manual. Chapter 3: NCPDP Flat File Format. Retrieved March 24, 2015, from https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/NCPDPflatfile.pdf

33 U.S. Department of Health and Human Services. Office of Inspector General. (2012, September). Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills. Retrieved March 24, 2015, from https://oig.hhs.gov/oei/reports/oei-02-09-00605.pdf

34 The United States Attorney's Office. Southern District of West Virginia. (2015, February 25). Trivillian's Pharmacy, Owner Plead Guilty to Federal Health Care and Drug Crimes. Retrieved March 30, 2015, from http://www.justice.gov/usao-sdwv/pr/trivillians-pharmacy-owner-plead-guilty-federal-health-care-and-drug-crimes

35 The United States Attorney's Office. District of Maryland. (2014, December 15). Federal Jury Convicts Pharmacy Store Owner of Health Care Fraud and Identity Theft. Retrieved March 17, 2015, from http://www.justice.gov/usao-md/pr/federal-jury-convicts-pharmacy-store-owner-health-care-fraud-and-identity-theft

36 Reporting and Returning of Overpayments, 42 U.S.C. § 1320d. Retrieved March 30, 2015, from http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7k&num=0&edition=prelim

37 Robertson, B. (2011, September/October). Reporting and Returning Medicare and Medicaid Overpayments. [Reprinted from Journal of Healthcare Compliance, 13(5).] Retrieved March 31, 2015, from http://www.huschblackwell.com/~/media/files/businessinsights/businessinsights/2011/09/reporting%20and%20returning%20medicare%20and%20medicaid%20ov__/files/reporting%20and%20returning%20medicare%20and%20medicaid%20ov__/fileattachment/jhcc_05-11_robertson.p

38 Romano, D.H. (2010, March). Compliance 101. The Fraud and Abuse Laws That Compliance Professionals Need to Know. Health Care Compliance Association. Retrieved April 1, 2015, from http://www.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2010/703handout7.pdf

39 U.S. Department of Justice. (n.d.). False Claims Act: A Primer. Retrieved March 31, 2015, from http://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

40 Romano, D.H. (2010, March). Compliance 101. The Fraud and Abuse Laws That Compliance Professionals Need to Know. Health Care Compliance Association. Retrieved April 1, 2015, from http://www.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2010/703handout7.pdf

41 Center for Program Integrity and Center for Medicaid and CHIP Services. (2012, January 20). CPI-CMCS Informational Bulletin. Retrieved April 1, 2015, from http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-20-12.pdf

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December 2015

December 2015

UCSF School of Pharmacy

Prospective DUR Updates: Q2 2018

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Prospective DUR Updates – Q1 2018

Topics for Discussion:

- New Generic Code Number (GCN) Alert Profiles
- Alert Priority Order
- Ingredient Duplication Alert Update: Emtricitabine
- Ingredient Duplication Alert Update: Lithium
- Drug-Pregnancy Alert Update

New GCN Alert Profiles

Background

- Each week new Generic Code Numbers (GCNs) are added
- Overutilization (ER) and Severity Level 1 Drug-Drug Interactions (DD) alerts are automatically turned on for all new GCNs
- New GCNs are reviewed weekly for additional alerts
- New GCNs with alerts turned on other than ER and DD is provided at each Board meeting for review

New GCN Alert Profiles (cont.)

Table 1. New GCNs for Existing DUR Target Drugs: Q2 2018

Date	GCN	Drug Description	Alerts Turned on
4/4/18	078238	MITOMYCIN	PG
4/4/18	078252	NILOTINIB HCL	PG
4/4/18	077567	PITAVASTATIN MAGNESIUM	PG, LR
4/4/18	077568	PITAVASTATIN MAGNESIUM	PG, LR
4/4/18	077569	PITAVASTATIN MAGNESIUM	PG, LR
4/4/18	078131	DIPHENHYDRAM/PE/DM/ACETAMIN/GG	ID, HD
4/4/18	078139	DIPHENHYDRAM/PE/DM/ACETAMIN/GG	ID, HD
4/11/18	078224	LAMIVUDINE/TENOFOVIR DISOP FUM	ID
4/11/18	078254	EFAVIRENZ/LAMIVU/TENOFOV DISOP	PG, ID
4/18/18	078264	PREDNISOLONE ACETATE/BROMFENAC	PG
4/18/18	078286	DUTASTERIDE	PG
4/25/18	078077	LEVONORGEST/ETH ESTRADIOL/IRON	PG, MC, TD, ID, HD, LD
5/9/18	078336	FENTANYL/BUP/IVACAINE/NS/PF	DA, MC, TD, AT, ID, HD, LD
5/23/18	075279	RITONAVIR	ID
5/23/18	027229	BACLOFEN	AT
5/30/18	068888	MORPHINE SULFATE/0.9% NACL/PF	DA, MC, TD, AT, ID, HD, LD
5/30/18	078185	AMANTADINE HCL	HD, LD
5/30/18	078186	AMANTADINE HCL	HD, LD
5/30/18	078187	AMANTADINE HCL	HD, LD
5/30/18	078426	NORTRIPTYLINE HCL	MC, TD, LR, AT, ID, HD, LD
6/6/18	078456	MORPHINE SULFATE	DA, MC, TD, AT, ID, HD, LD
6/6/18	078461	ABIRATERONE ACET,SUBMICRONIZED	PG
6/13/18	078432	EPOETIN ALFA-EPBX	DA, MC, TD, ID, HD, LD
6/13/18	078433	EPOETIN ALFA-EPBX	DA, MC, TD, ID, HD, LD
6/13/18	078434	EPOETIN ALFA-EPBX	DA, MC, TD, ID, HD, LD
6/13/18	078435	EPOETIN ALFA-EPBX	DA, MC, TD, ID, HD, LD
6/13/18	078481	OMEPRAZOLE	TD, ID, HD, LD
6/20/18	078436	EPOETIN ALFA-EPBX	DA, MC, TD, ID, HD, LD
6/20/18	078487	TIMOLOL/DORZOLAMIDE/LATANOP/PF	PG
6/20/18	078488	DORZOLAMIDE/TIMOLOL/PF	PG
6/20/18	078497	TIMOLOL/BRIMONIDIN/DORZOLAM/PF	PG
6/20/18	078505	TIMOLO/BRIMON/DORZO/LATANOP/PF	PG
6/27/18	078532	OXYCODONE HCL	DA, MC, TD, AT, ID, HD, LD
6/27/18	078533	OXYCODONE HCL	DA, MC, TD, AT, ID, HD, LD
6/27/18	078498	MITOMYCIN	PG
6/27/18	067584	HYDROXYUREA	PG
6/27/18	078504	TIMOLOL MALEATE/LATANOPROST/PF	PG
6/27/18	078477	ESTRADIOL	PG, MC
6/27/18	078478	ESTRADIOL	PG, MC

Board questions/recommendations?

Alert Priority Order

Multiple alerts on a prescription are prioritized by therapeutic problem type according to the following hierarchy:

1. Drug-allergy conflict (DA)
2. Drug-pregnancy conflict (PG)
3. Drug-disease conflict (MC)
4. Drug-drug interaction (DD) – other pharmacy
5. Therapeutic duplication (TD)
6. Overutilization (ER)
7. Underutilization (LR)
8. Additive Toxicity (AT)
9. Ingredient duplication (ID)
10. Drug-age conflict (PA)
11. Drug-drug interaction (DD) – same pharmacy
12. Incorrect dose (HD/LD/PHD/PLD)

Board questions/recommendations?

Ingredient Duplication Alert Update: Emtricitabine

- Review of emtricitabine ingredient duplication (ID) alerts presented at September 2017 Board meeting
- Majority of alerts (78%) due to switch from regimen containing tenofovir disoproxil fumarate to regimen containing tenofovir alafenamide
- Board recommended reviewing again in one year to see if regimens stabilized and ID alerts decreased

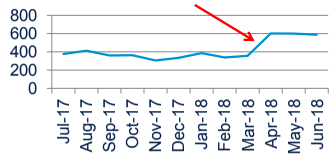
Ingredient Duplication Alert Update: Emtricitabine (cont.)

Table 1. Drugs Generating Ingredient Duplication (ID) Alerts for Emtricitabine between July 1, 2017, and June 30, 2018 (n = 5,258)

Drug	Total ID Alerts (%)
emtricitabine/tenofovir alafenamide	1,355 (26%)
bictegravir/emtricitabine/tenofovir alafenamide	1,220 (23%)
elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide	1,126 (21%)
emtricitabine/rilpivirine/tenofovir alafenamide	520 (10%)
emtricitabine/tenofovir disoproxil	461 (9%)
efavirenz/emtricitab/tenofovir disoproxil	247 (5%)
emtricitabine/rilpivirine/tenofovir disoproxil	149 (3%)
elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil	139 (3%)
emtricitabine	41 (1%)

Ingredient Duplication Alert Update: Emtricitabine (cont. 2)

- Number of emtricitabine ID alerts decreased by 26% in one year
- Spike in alerts after new drug approved by FDA



- 23% of all ID alerts for emtricitabine due to new drug

Board questions/recommendations?

Ingredient Duplication Alert Update: Lithium

- A review of all March 2018 prospective DUR alerts showed some formulations of lithium are still generating ID alerts, even when neither drug is a 300 mg formulation
  - Example: A claim for lithium carbonate 150 mg capsules generated an ID alert based on claim history of lithium carbonate ER 450 mg tablets
- Review of June 2018 data showed 150 mg formulations still generating alerts
- August 2018 problem fixed for 150 mg formulations

Board questions/recommendations?

Drug-Pregnancy Alert Update

- Board recommended annual review of drug-pregnancy (PG) alert
  - Time-consuming
  - Discrepancies, especially when severity level changes
- PG alert now on for all drugs (including new GCNs), effective September 2018
  - Precedence with drug-drug interaction alert (only sends alert on severity level 1)
  - No change in total PG alerts generated
  - Potential for errors decreased + saves time

Board questions/recommendations?

UCSF School of Pharmacy

Summary of Activities: DUR Educational Outreach

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DUR Educational Outreach

Topics for Discussion:

- Proposal: Additive Toxicity
- Outcomes: Buprenorphine
- Outcomes: NRT
- Updated Outcomes: Early Refill
- Updated Outcomes: Fluoroquinolones

Letter Proposal: Additive Toxicity - 1

Background:

- FDA requiring changes to drug labeling due to serious risks associated with the use of opioids in combination with benzodiazepines and other CNS depressants
- Medi-Cal DUR program now focusing the additive toxicity (AT) alert on CNS depressants
- In June 2018, a total of 307 Medi-Cal FFS beneficiaries generated AT alerts due to concomitant use of opioids, benzodiazepines, and at least one additional CNS depressant

Letter Proposal: Additive Toxicity - 2

Objectives:

- To identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants
- To help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics

Letter Proposal: Additive Toxicity - 3

Methods:

- All FFS beneficiaries generating an AT alert for a combination of opioids, benzodiazepines, and other CNS depressants will be included in the study population (during a selected month)
  - Exclusions include cancer and/or those receiving hospice care
  - Prescribers will be sent a packet including patient profiles, the additive toxicity bulletin, information on naloxone, and a provider survey (for each patient)

Letter Proposal: Additive Toxicity - 4

Outcomes:

- Primary outcome
  - Total continuously-eligible beneficiaries without active paid claims for both opioids and benzodiazepines after 6 months following the mailing
- Secondary outcome
  - Total continuously-eligible beneficiaries with a paid claim for naloxone within the 6 months following the mailing

Board recommendations?

Outcomes: Buprenorphine - 1

Background:

- In 2016, the DUR program sent letters to the top100 prescribers (by total quantity prescribed) of opioids without a current buprenorphine waiver
  - Included the buprenorphine article, encouraged providers to complete training
- Within 12 months 5 providers completed the training and quantity of opioids prescribed by these providers decreased 30%
- May 2018 the Board recommended repeat of mailing

Outcomes: Buprenorphine - 2

Objectives:

- To inform providers that buprenorphine use among Medi-Cal fee-for-service beneficiaries is associated with high adherence rates and decreased concomitant use of high-risk medications, including other opioids
- To increase the number of Medi-Cal patients receiving treatment with buprenorphine
- To increase the number of Medi-Cal providers able to provide buprenorphine treatment

Outcomes: Buprenorphine - 3

Methods:

- Top 100 opioid prescribers (by billed quantity) across all Medi-Cal (includes FFS and MCP) without a waiver to provide buprenorphine treatment
  - Excluded providers who had already received mailing
- Letters included Medi-Cal DUR buprenorphine article and provider response survey
- Letters mailed August 23, 2018

Outcomes: Buprenorphine - 4

Outcomes:

- Primary outcome
  - Total number of providers (all of Medi-Cal) completing the buprenorphine training within 12 months after the mailing
- Secondary outcomes
  - Total number of paid claims for buprenorphine by these providers within 12 months after the mailing
  - Total billed quantity of opioids by these providers within 12 months after the mailing

Outcomes: NRT - 1

Background:

- While the regulation allowing pharmacists in California to furnish NRT became effective over two years ago, claims data for the Medi-Cal fee-for-service program shows limited adoption
- Estimated smoking prevalence among adult Medi-Cal beneficiaries in 2016 was 16.0% (versus 11.2% statewide)
  - County rates vary from 6.6% (San Mateo) to 28.0% (Lake)

Outcomes: NRT - 2

Objectives:

- To inform pharmacy directors of the protocol for pharmacist furnishing of NRT in California, including training requirements
- To increase the number of pharmacists able to furnish NRT
- To increase the number of Medi-Cal beneficiaries with a paid claim for NRT

Outcomes: NRT - 3

Methods:

- A total of 172 California pharmacies were selected based on geography and volume
  - At least 100 Medi-Cal utilizing beneficiaries since July 1, 2018
  - Practice location in Colusa, Del Norte, Fresno, Glenn, Lake, Mariposa, Merced, Shasta, Siskiyou, Stanislaus, Tehama, Trinity, Tulare, Tuolumne, Yuba counties (top adult smoking rate counties)
- Letters mailed August 23, 2018

Outcomes: NRT - 4

Outcomes:

- Primary outcome
  - Number of paid claims for pharmacist-furnished NRT within the 12-month period following the mailing of the intervention letter
- Secondary outcomes
  - Total pharmacists in each of the 15 counties successfully completing a DHCS 6219 application within 12 months of mailing
  - Total pharmacists in each of the 15 counties furnishing NRT within 12 months of mailing

Updated Outcomes: Early Refill - 1

Background:

- Early refill (ER) alerts generated when the most recent prescription for the same beneficiary has > 25% days' supply left
- May indicate drug overutilization due to or an increased potential for fraud, abuse, and diversion
- DUR review of ER alerts showed majority of pharmacies use the ER alert sparingly
  - Top 100 pharmacies by ER override were responsible for 29.4% of overrides, but only 18.4% of claims

Updated Outcomes: Early Refill - 2

Objectives:

- To assess the feasibility and acceptability of DUR educational outreach letters to pharmacies
- To decrease the total volume of early refill overrides by pharmacies

Updated Outcomes: Early Refill - 3

Methods:

- The top 100 pharmacies by total number of ER alert overrides in the Medi-Cal fee-for-service program during calendar year 2016 were sent outreach letter
  - Included pharmacy ranking by number of ER alert overrides (overall ER overrides and ER overrides of scheduled medications)

Updated Outcomes: Early Refill - 4

Outcomes:

- Rate of undeliverable letters (within 90 days): 0%
- Provider response rate (within 90 days): 29%
- Primary outcome
  - 25% decrease in the number of ER alert overrides among the 100 pharmacies who received the mailing
    - 4% increase in ER overrides among all other pharmacies who did not receive mailing (n = 5,001)
  - No statistically significant difference in paid claims (among top 100)

Board recommendations?

Updated Outcomes: Fluoroquinolones - 1

Background:

- FDA recommends that fluoroquinolones should not be prescribed to patients who have other treatment options for acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, and uncomplicated urinary tract infections
- DUR study found that 68% of fluoroquinolone use in the Medi-Cal FFS population appeared to be potentially inappropriate, based on the new FDA recommendations

Updated Outcomes: Fluoroquinolones - 2

Objectives:

- To inform providers of the FDA-approved safety labeling changes for fluoroquinolones
- To decrease the number of Medi-Cal patients receiving treatment with fluoroquinolones for acute bacterial exacerbation of chronic bronchitis, acute sinusitis, and uncomplicated UTI

Updated Outcomes: Fluoroquinolones - 3

Methods:

- The top 100 prescribers (by total number of paid claims prescribed) of fluoroquinolones in the Medi-Cal FFS program between January 1, 2017 and June 30, 2017 were sent a packet that included the DUR bulletin on fluoroquinolones

Updated Outcomes: Fluoroquinolones - 4

Outcomes:

- Rate of undeliverable letters (within 90 days): 15%
- Provider response rate (within 90 days): 10%
- Primary outcome
  - 41% decrease in the number of paid claims for fluoroquinolone among prescribers who received the mailing (n = 85)
    - 16% decrease among prescribers who did not receive the mailing (n = 15)
  - Similar difference seen among total utilizing beneficiaries (39% decrease vs. 5% decrease)

Updated Outcomes: Fluoroquinolones - 5

Outcomes (cont.):

- A total of 22 prescribers who received the mailing showed increases in paid claims for recommended first line treatments:
  - Acute sinusitis and acute exacerbation of chronic bronchitis due to a bacterial pathogen: amoxicillin, amoxicillin/clavulanate, doxycycline
  - Uncomplicated UTIs: trimethoprim/sulfamethoxazole, nitrofurantoin monohydrate/macrocrystals
- Prescribers who did not receive mailing did not show increase
- Not statistically significant in aggregate

Board recommendations?

Next Board Meeting

November 2018:

- Proposal: LTBI
- Outcomes: MEDD 2018

Future Topics

DUR Educational Outreach to Pharmacies/Providers:

- Over-the-Counter Medications
- QT Prolongation
- Late Refill
- Today's topic: Additive Toxicity

Board recommendations?

QUARTERLY SUMMARY
DRUG USE REVIEW (DUR) UTILIZATION REVIEW
REPORT PERIOD: 2nd QUARTER 2018 (APRIL - JUNE 2018)

Executive Summary

The DUR quarterly report provides information on both prospective and retrospective drug utilization for the Medi-Cal Fee-for-Service (FFS) program. For this quarterly report, the prospective and retrospective data cover the second quarter of 2018 (2018 Q2). All tables can be found in **Appendix A** and definitions of selected terms can be found in **Appendix B**.

Prospective DUR

As shown in **Table 1.1**, in 2018 Q2 overall drug claims decreased by 5% and total DUR alerts decreased by less than 1% in comparison to the prior quarter (2018 Q1). However, in comparison to the prior-year quarter (2017 Q2), overall drug claims decreased by 2% and total DUR alerts increased by 12%. The increase in total DUR alerts is due to an update to the therapeutic duplication (TD) alert, which was effective October 24, 2017. The number of TD alerts increased 107% in one year (went from 185,801 TD alerts in 2017 Q1 to 384,007 alerts in 2018 Q1).

A comparison between 2018 Q2 and 2018 Q1 showed few changes among the top 10 drugs for each of the 12 prospective DUR alerts (**Tables 2.1-2.12**). Of note, the low dose (LD) alert for LITHIUM is now off, effective February 27, 2018, and so LITHIUM went from beging top-ranked drug for LD alerts to not have any LD alerts.

Retrospective DUR

For the first time, this quarterly report contains fee-for-service pharmacy utilization data presented in aggregate (**Tables 3.1, 4.1, 5.1**, and **6.1**), by Medi-Cal FFS enrollees only (**Tables 3.2, 4.2, 5.2**, and **6.2),** and by Medi-Cal managed care plan (MCP) enrollees only (**Tables 3.3, 4.3, 5.3**, and **6.3)**.

In addition, this report now includes Medi-Cal fee-for-service paid claims from all eligible beneficiaries in the Family Planning, Access, Care, and Treatment (Family PACT) program and the California Children's Services/ Genetically Handicapped Persons Program (CCS/GHPP).

In 2018 Q2, approximately 15% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal fee-for-service program, compared with only 2% of Medi-Cal MCP enrollees (**Table 3.2** and **Table 3.3**,). Among all Medi-Cal beneficiaires with a paid claim through the Medi-Cal fee-for-service program in 2018 Q2, 63% were FFS enrollees and 38% were MCP enrollees (numbers add up to greater than 100% due to some beneficiairies being enrolled in both programs during 2018 Q2).

Of note, **Table 5.2** and **Table 6.2** show the top 20 drug therapeutic drug categories and top 20 drugs of Medi-Cal FFS program enrollees, while **Table 5.3** and **Table 6.3** show the top 20 drug therapeutic drug categories and top 20 drugs by beneficiaries enrolled in Medi-Cal MCPs. These tables give a more in-depth look at the impact of carved-out drugs on tables showing overall pharmacy utilization in the Medi-Cal fee-for-service program **(Table 5.1** and **Table 6.1**).

Appendix A: Prospective and Retrospective DUR Tables

Tables 1.1-1.2. Summary of Prospective DUR Alert Transactions.

Table 1.1 provides summary level data (by volume) on pharmacy claims and DUR alert activities, including data and percent change from the prior quarter. Alerts are generated after adjudication of drug claims which exceed or otherwise fall outside of certain prescribed parameters. Please see **Appendix B** for definitions of terms used in this DUR report.

Table 1.1: Summary of Alert Transactions					
Category	Current Quarter 2018 Q2 (Apr – Jun 2018)	Prior Quarter 2018 Q1 (Jan – Mar 2018)	% Change from *Prior Quarter*	Prior-Year Quarter 2017 Q2 (Apr – Jun 2017)	% Change from *Prior-Year Quarter*
Drug Claims	7,872,048	8,324,737	**-5.4%**	8,042,813	**-2.1%**
DUR Drug Claims	3,807,244	4,000,078	**-4.8%**	3,906,086	**-2.5%**
Total Alerts	1,072,091	1,079,784	**-0.7%**	957,660	**11.9%**
Total Alert Overrides	678,835	679,372	**-0.1%**	572,597	**18.6%**
Total Alert Cancels	353	235	**50.2%**	135	**161.5%**

Note: Drug claims receiving multiple alerts can be adjudicated by pharmacists by responding to only one conflict code, followed by an intervention code and outcome code. The remaining alerts on the claim cannot be tracked as they are overridden by the pharmacist's response to a single alert. For example, a single claim can generate up to eight different alerts, but the pharmacist can override all eight alerts by choosing to override only one alert. In addition, the number of cancelled alerts may be underrepresented due to the system's inability to capture claims that were not adjudicated.

Table 1.2 provides a summary of the number of drug claims and alerts generated for each therapeutic problem type (sorted by alert frequency). Total alerts not adjudicated may be overrepresented, as claims with multiple alerts that have been adjudicated under one alert will show up as not adjudicated for the remaining alerts.

Table 1.2: Summary of Alert Transactions by Therapeutic Problem Type – 2018 Q2							
Therapeutic Problem Type	Total Alerts	Total Alert Over-rides	% Alert Over-rides	Total Alert Cancels	% Alert Cancels	Total Alerts Not Adjud-icated	% Alerts Not Adjud-icated
Therapeutic Duplication (TD)	384,007	288,196	75.0%	89	0.0%	95,722	24.9%
Early Refill (ER)	284,966	94,507	33.2%	124	0.0%	190,335	66.8%
Ingredient Duplication (ID)	166,266	121,101	72.8%	44	0.0%	45,121	27.1%
Late Refill (LR)	112,544	87,481	77.7%	50	0.0%	25,013	22.2%
Total High Dose (HD)	44,797	28,842	64.4%	19	0.0%	15,936	35.6%
Additive Toxicity (AT)	35,148	28,593	81.4%	8	0.0%	6,547	18.6%
Drug-Pregnancy (PG)	20,439	13,547	66.3%	6	0.0%	6,886	33.7%
Total Low Dose (LD)	13,305	8,675	65.2%	3	0.0%	4,627	34.8%
Drug-Drug (DD)	7,713	5,867	76.1%	1	0.0%	1,845	23.9%
Drug-Disease (MC)	2,411	1,685	69.9%	0	0.0%	726	30.1%
Drug-Allergy (DA)	350	243	69.4%	0	0.0%	107	30.6%
Drug-Age (PA)	145	98	67.6%	0	0.0%	47	32.4%

Tables 2.1-2.12. Prospective DUR Alert Transactions by Therapeutic Problem Type.

Each of the following tables provides greater detail of each of the 12 DUR alerts with the top 10 drugs generating each respective alert. For each of the top 10 drugs, data are provided for the total number of adjudicated alerts, alert overrides, alert cancels, paid claims, and the percentage of paid claims with alert overrides. **Tables are listed in order of DUR alert priority, which is determined by the DUR Board.**

Table 2.1: Top 10 Drugs by Therapeutic Problem Type – Drug-Allergy (DA) – 2018 Q2

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	PHENYTOIN SODIUM EXTENDED	46	46	0	1,843	2.5%
2	PHENYTOIN	43	41	2	752	5.5%
3	OXYCODONE HCL	12	12	0	3,729	0.3%
4	OXYCODONE HCL/ACETAMINOPHEN	7	6	1	4,566	0.1%
5	AMOXICILLIN	6	6	0	34,746	0.0%
6	IBUPROFEN	5	5	0	77,646	0.0%
7	LITHIUM CARBONATE	3	3	0	30,446	0.0%
8	PROMETHAZINE HCL/CODEINE	3	3	0	4,581	0.1%
9	ZIPRASIDONE HCL	3	3	0	17,336	0.0%
10	AMOXICILLIN/POTASSIUM CLAV	2	2	0	10,175	0.0%

Table 2.2: Top 10 Drugs by Therapeutic Problem Type – Drug-Pregnancy (PG) – 2018 Q2

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	IBUPROFEN	13,198	13,192	6	77,646	17.0%
2	NORETHINDRONE	2,533	2,533	0	7,010	36.1%
3	METHYLERGONOVINE MALEATE	378	378	0	179	211.2%
4	MISOPROSTOL	367	367	0	592	62.0%
5	NAPROXEN	291	291	0	12,490	2.3%
6	LISINOPRIL	119	119	0	32,848	0.4%
7	METHIMAZOLE	115	115	0	1,491	7.7%
8	ULIPRISTAL ACETATE	94	94	0	805	11.7%
9	INDOMETHACIN	84	84	0	799	10.5%
10	NONOXYNOL 9	71	71	0	11,134	0.6%

Table 2.3: Top 10 Drugs by Therapeutic Problem Type – Drug-Disease (MC) – 2018 Q2

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	POTASSIUM CHLORIDE	378	378	0	3,270	11.6%
2	METFORMIN HCL	330	329	1	41,215	0.8%
3	HALOPERIDOL	303	303	0	21,232	1.4%
4	METOPROLOL TARTRATE	84	84	0	7,398	1.1%
5	CARBAMAZEPINE	59	59	0	3,038	1.9%
6	LEVONORGESTREL-ETHIN ESTRADIOL	56	56	0	18,016	0.3%
7	HALOPERIDOL DECANOATE	54	54	0	4,242	1.3%
8	METOPROLOL SUCCINATE	50	50	0	6,133	0.8%
9	NORELGESTROMIN/ETHIN.ESTRADIOL	40	40	0	10,348	0.4%
10	DILTIAZEM HCL	36	36	0	1,526	2.4%

Table 2.4: Top 10 Drugs by Therapeutic Problem Type – Drug-Drug Interaction (DD) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ELVITEG/COB/EMTRI/TENOF ALAFEN	783	783	0	14,128	5.5%
2	DARUNAVIR ETHANOLATE	664	664	0	4,156	16.0%
3	GEMFIBROZIL	561	561	0	2,451	22.9%
4	SIMVASTATIN	369	369	0	10,183	3.6%
5	ATORVASTATIN CALCIUM	336	336	0	29,622	1.1%
6	DARUNAVIR/COBICISTAT	199	199	0	5,480	3.6%
7	AMLODIPINE BESYLATE	194	194	0	21,785	0.9%
8	ETRAVIRINE	182	182	0	862	21.1%
9	BUPRENORPHINE HCL/ NALOXONE HCL	115	115	0	34,734	0.3%
10	LURASIDONE HCL	110	110	0	40,432	0.3%

Table 2.5: Top 10 Drugs by Therapeutic Problem Type – Therapeutic Duplication (TD) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	73,201	73,176	25	139,329	52.5%
2	OLANZAPINE	25,803	25,798	5	78,405	32.9%
3	ARIPIPRAZOLE	23,779	23,767	12	104,131	22.8%
4	RISPERIDONE	21,111	21,107	4	83,113	25.4%
5	HALOPERIDOL	12,967	12,963	4	21,232	61.1%
6	LURASIDONE HCL	12,914	12,911	3	40,432	31.9%
7	CLOZAPINE	11,791	11,791	0	20,748	56.8%
8	PALIPERIDONE PALMITATE	7,278	7,278	0	18,127	40.2%
9	ZIPRASIDONE HCL	5,574	5,571	3	17,336	32.1%
10	CHLORPROMAZINE HCL	5,044	5,042	2	6,022	83.7%

Table 2.6: Top 10 Drugs by Therapeutic Problem Type – Overutilization (ER) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	7,160	7,151	9	139,329	5.1%
2	ARIPIPRAZOLE	6,106	6,103	3	104,131	5.9%
3	RISPERIDONE	4,825	4,821	4	83,113	5.8%
4	BENZTROPINE MESYLATE	4,195	4,194	1	55,396	7.6%
5	OLANZAPINE	4,166	4,160	6	78,405	5.3%
6	LITHIUM CARBONATE	2,582	2,581	1	30,446	8.5%
7	LURASIDONE HCL	2,177	2,174	3	40,432	5.4%
8	ASPIRIN	2,067	2,066	1	53,667	3.8%
9	METFORMIN HCL	1,765	1,763	2	41,215	4.3%
10	BUPRENORPHINE HCL/ NALOXONE HCL	1,589	1,588	1	34,734	4.6%

Table 2.7: Top 10 Drugs by Therapeutic Problem Type – Underutilization (LR) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ARIPIPRAZOLE	14,920	14,910	10	104,131	14.3%
2	QUETIAPINE FUMARATE	13,827	13,820	7	139,329	9.9%
3	RISPERIDONE	8,875	8,871	4	83,113	10.7%
4	OLANZAPINE	6,989	6,984	5	78,405	8.9%
5	BENZTROPINE MESYLATE	6,730	6,729	1	55,396	12.1%
6	LURASIDONE HCL	5,094	5,093	1	40,432	12.6%
7	LITHIUM CARBONATE	4,205	4,202	3	30,446	13.8%
8	ATORVASTATIN CALCIUM	3,272	3,270	2	29,622	11.0%
9	LEVOTHYROXINE SODIUM	2,877	2,877	0	25,279	11.4%
10	GABAPENTIN	2,457	2,456	1	23,246	10.6%

Table 2.8: Top 10 Drugs by Therapeutic Problem Type – Additive Toxicity (AT) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	LITHIUM CARBONATE	1,571	1,571	0	30,446	5.2%
2	LORAZEPAM	1,488	1,488	0	8,540	17.4%
3	CLONAZEPAM	1,245	1,245	0	6,897	18.1%
4	BACLOFEN	1,165	1,165	0	13,613	8.6%
5	HYDROCODONE/ACETAMINOPHEN	1,020	1,020	0	29,442	3.5%
6	QUETIAPINE FUMARATE	784	782	2	139,329	0.6%
7	ARIPIPRAZOLE	667	666	1	104,131	0.6%
8	BUSPIRONE HCL	570	570	0	3,567	16.0%
9	OLANZAPINE	515	515	0	78,405	0.7%
10	ZOLPIDEM TARTRATE	477	477	0	2,919	16.3%

Table 2.9: Top 10 Drugs by Therapeutic Problem Type – Ingredient Duplication (ID) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	13,701	13,696	5	78,405	17.5%
2	ARIPIPRAZOLE	12,295	12,290	5	104,131	11.8%
3	RISPERIDONE	11,075	11,071	4	83,113	13.3%
4	ALBUTEROL SULFATE	6,615	6,609	6	40,653	16.3%
5	CLOZAPINE	6,116	6,116	0	20,748	29.5%
6	LURASIDONE HCL	5,668	5,666	2	40,432	14.0%
7	ZIPRASIDONE HCL	3,274	3,272	2	17,336	18.9%
8	LEVOTHYROXINE SODIUM	3,143	3,142	1	25,279	12.4%
9	BENZTROPINE MESYLATE	2,383	2,382	1	55,396	4.3%
10	HALOPERIDOL	2,345	2,343	2	21,232	11.0%

Table 2.10: Top 10 Drugs by Therapeutic Problem Type – Drug-Age (PA) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AMITRIPTYLINE HCL	153	153	0	3,345	4.6%
2	ACETAMINOPHEN WITH CODEINE	78	78	0	7,621	1.0%
3	CODEINE PHOSPHATE/GUAIFENESIN	34	34	0	3,004	1.1%
4	DOXEPIN HCL	9	9	0	387	2.3%
5	DEXTROAMPHETAMINE/ AMPHETAMINE	4	4	0	4,750	0.1%
6	FILGRASTIM	4	4	0	397	1.0%
7	MYCOPHENOLATE MOFETIL	4	4	0	2,740	0.1%
8	ADALIMUMAB	3	3	0	1,197	0.3%
9	ASPIRIN	3	3	0	53,667	0.0%
10	DEFERASIROX	3	3	0	508	0.6%

Table 2.11: Top 10 Drugs by Therapeutic Problem Type – High Dose (HD) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	6,627	6,621	6	78,405	8.4%
2	RISPERIDONE	2,355	2,354	1	83,113	2.8%
3	QUETIAPINE FUMARATE	1,474	1,471	3	139,329	1.1%
4	HYDROCODONE/ACETAMINOPHEN	1,348	1,347	1	29,442	4.6%
5	GABAPENTIN	1,320	1,320	0	23,246	5.7%
6	IBUPROFEN	1,089	1,089	0	77,646	1.4%
7	AMOXICILLIN	744	744	0	34,746	2.1%
8	AMOXICILLIN/POTASSIUM CLAV	716	716	0	10,175	7.0%
9	ARIPIPRAZOLE	653	653	0	104,131	0.6%
10	FAMOTIDINE	542	542	0	14,103	3.8%

Table 2.12: Top 10 Drugs by Therapeutic Problem Type – Low Dose (LD) – 2018 Q2						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AZITHROMYCIN	970	970	0	18,511	5.2%
2	GABAPENTIN	907	906	1	23,246	3.9%
3	DIVALPROEX SODIUM	818	818	0	11,280	7.3%
4	AMOXICILLIN	565	565	0	34,746	1.6%
5	ERYTHROMYCIN ETHYLSUCCINATE	401	401	0	1,751	22.9%
6	DULOXETINE HCL	376	376	0	3,761	10.0%
7	AMOXICILLIN/POTASSIUM CLAV	330	330	0	10,175	3.2%
8	ALBUTEROL SULFATE	313	313	0	40,653	0.8%
9	BUPROPION HCL	306	306	0	6,049	5.1%
10	SULFAMETHOXAZOLE/TRIMETHOPRIM	273	273	0	15,994	1.7%

Tables 3.1-3.3. Summary of Medi-Cal FFS Pharmacy Utilization.

These tables shows pharmacy utilization for the Medi-Cal population, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 3.2** and **Table 3.3**, as enrollment status may change.

Table 3.1: Fee-for-Service Pharmacy Utilization Measures for the Entire Medi-Cal Population

Category	Current Quarter 2018 Q2	Prior Quarter 2018 Q1	Prior-Year Quarter 2017 Q2	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	15,605,773	15,796,804	15,957,797	**-1.2%**	**-2.2%**
Total Utilizing Beneficiaries	728,055	1,428,173	1,368,303	**-49.0%**	**-46.8%**
Total Paid Rx Claims	2,552,477	2,689,123	2,637,427	**-5.1%**	**-3.2%**
Average Paid Rx Claims per Eligible Beneficiary	0.16	0.17	0.17	**-3.9%**	**-1.0%**
Average Paid Rx Claims per Utilizing Beneficiary	3.51	1.88	1.93	**86.2 %**	**81.9%**

Table 3.2: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal FFS Population Only

Category	Current Quarter 2018 Q2	Prior Quarter 2018 Q1	Prior-Year Quarter 2017 Q2	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	3,148,393	3,333,605	3,454,064	**-5.6%**	**-8.9%**
Total Utilizing Beneficiaries	459,060	1,096,077	1,041,455	**-58.1%**	**-55.9%**
Total Paid Rx Claims	1,629,893	1,774,570	1,736,033	**-8.2%**	**-6.1%**
Average Paid Rx Claims per Eligible Beneficiary	0.52	0.53	0.50	**-2.8%**	**3.0%**
Average Paid Rx Claims per Utilizing Beneficiary	3.55	1.62	1.67	**119.3%**	**113.0%**

Table 3.3: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal MCP Population Only

Category	Current Quarter 2018 Q2	Prior Quarter 2018 Q1	Prior-Year Quarter 2017 Q2	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	12,880,908	12,915,416	13,024,883	**-0.3%**	**-1.1%**
Total Utilizing Beneficiaries	274,301	337,715	332,248	**-18.8%**	**-17.4%**
Total Paid Rx Claims	922,584	914,553	901,394	**0.9%**	**2.4%**
Average Paid Rx Claims per Eligible Beneficiary	0.07	0.07	0.07	**1.2%**	**3.5%**
Average Paid Rx Claims per Utilizing Beneficiary	3.36	2.71	2.71	**24.2%**	**24.0%**

Tables 4.1-4.3. Pharmacy Utilization by Age Group in the Medi-Cal Population.

This table presents pharmacy utilization data broken out by age group, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 4.2** and **Table 4.3**, as enrollment status may change.

Table 4.1: Fee-for-Service Pharmacy Utilization by Age Group for the Entire Medi-Cal Population

Age Group (years)	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	271,881	-17.7%	-10.6%	87,382	-56.8%	-51.3%
13 – 18	174,749	-5.1%	-2.3%	45,125	-48.9%	-45.8%
19 – 39	794,775	-2.8%	0.1%	251,800	-44.8%	-42.5%
40 – 64	1,106,599	-3.0%	-2.8%	275,720	-50.2%	-48.7%
65+	204,472	-5.2%	-8.2%	68,027	-46.8%	-47.6%
Total*	2,552,477	-5.1%	-3.2%	731,844	-49.0%	-46.8%

Table 4.2: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal FFS Population Only

Age Group (years)	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	174,904	-24.1%	-15.6%	66,958	-59.0%	-52.8%
13 – 18	92,517	-9.7%	-6.7%	24,379	-57.0%	-53.5%
19 – 39	471,636	-6.1%	-3.7%	153,556	-55.2%	-53.3%
40 – 64	695,297	-5.1%	-4.2%	149,265	-63.5%	-61.9%
65+	195,538	-5.5%	-8.7%	64,901	-47.8%	-48.6%
Total*	1,629,893	-8.2%	-6.1%	459,060	-58.1%	-55.9%

Table 4.3: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal MCP Population Only

Age Group (years)	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	96,977	-3.1%	0.1%	20,774	-47.5%	-45.5%
13 – 18	82.232	0.6%	3.0%	21,036	-34.0%	-32.8%
19 – 39	323,139	2.5%	6.2%	100,737	-13.0%	-9.8%
40 – 64	411,302	0.7%	-0.2%	128,553	-12.5%	-12.8%
65+	8,934	2.1%	6.0%	3,201	-12.0%	-13.3%
Total*	922,584	0.9%	2.4%	274,301	-18.8%	-17.4%

* Unknowns represent less than 1% of total

Tables 5.1-5.3. Top 20 Drug Therapeutic Categories in the Medi-Cal Population.

This table presents utilization of the top 20 drug therapeutic categories, by **total utilizing beneficiaries.** The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization and reimbursement dollars paid to pharmacies for these top utilized drugs. The prior-year quarter ranking of the drug therapeutic category is listed for reference.

Table 5.1: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE ,SEROTONIN ANTAGNST	409,226	**1.1%**	**0.6%**	156,787	21.5%	**0.5%**	**0.1%**
2	2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	95,773	**-13.1%**	**-4.9%**	83,877	11.5%	**-13.4%**	**-5.1%**
3	4	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	109,580	**2.4%**	**3.3%**	47,564	6.5%	**1.5%**	**2.8%**
4	3	PENICILLIN ANTIBIOTICS	49,516	**-24.7%**	**-9.4%**	45,674	6.3%	**-25.0%**	**-9.5%**
5	7	ANTICONVULSANTS	87,278	**-1.8%**	**-2.0%**	40,452	5.6%	**-2.5%**	**-1.6%**
6	6	PLATELET AGGREGATION INHIBITORS	55,701	**-0.5%**	**-13.3%**	38,100	5.2%	**-0.8%**	**-11.7%**
7	5	NARCOTIC ANALGESIC AND NON-SALICYLATE ANALGESIC	41,609	**-7.0%**	**-21.5%**	34,597	4.8%	**-7.1%**	**-20.8%**
8	8	ANTIHISTAMINES - 2ND GENERATION	45,463	**0.3%**	**-10.8%**	30,351	4.2%	**-2.0%**	**-11.3%**
9	9	LAXATIVES AND CATHARTICS	45,166	**-2.5%**	**-10.6%**	29,958	4.1%	**-3.5%**	**-10.8%**
10	14	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	44,995	**-1.2%**	**3.1%**	29,730	4.1%	**-1.5%**	**4.6%**
11	13	IRON REPLACEMENT	39,543	**-0.5%**	**0.4%**	29,488	4.1%	**-1.2%**	**0.7%**
12	11	ANTIHYPERTENSIVES, ACE INHIBITORS	44,923	**-1.4%**	**-2.3%**	29,243	4.0%	**-2.0%**	**-1.8%**
13	12	INSULINS	54,097	**-0.8%**	**-2.0%**	29,142	4.0%	**-1.5%**	**-1.1%**
14	10	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	41,690	**-27.4%**	**-10.5%**	28,528	3.9%	**-31.9%**	**-12.4%**
15	15	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	41,181	**-0.5%**	**0.8%**	27,219	3.7%	**-0.8%**	**1.5%**
16	16	ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC	60,863	**0.4%**	**-1.4%**	23,963	3.3%	**-0.3%**	**-2.4%**
17	17	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	23,916	**-0.2%**	**-2.3%**	22,553	3.1%	**0.2%**	**-1.8%**
18	20	PRENATAL VITAMIN PREPARATIONS	24,254	**-0.5%**	**9.1%**	21,447	3.0%	**-1.0%**	**9.9%**
19	19	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	36,694	**-3.2%**	**-4.0%**	20,650	2.8%	**-4.0%**	**-3.6%**
20	18	TOPICAL ANTI-INFLAMMATORY STEROIDAL	23,657	**-0.6%**	**-8.7%**	20,459	2.8%	**-0.7%**	**-8.4%**

Table 5.2: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	94,390	-13.2%	-4.7%	82,802	18.0%	-13.4%	-4.9%
2	2	PENICILLIN ANTIBIOTICS	48,435	-24.8%	-9.3%	44,919	9.8%	-25.0%	-9.3%
3	4	PLATELET AGGREGATION INHIBITORS	54,597	-0.5%	-13.3%	37,472	8.2%	-0.7%	-11.4%
4	3	NARCOTIC ANALGESIC AND NON-SALICYLATE ANALGESIC	40,902	-6.9%	-21.3%	33,985	7.4%	-7.1%	-20.6%
5	5	ANTICONVULSANTS	70,383	-2.4%	-3.7%	33,660	7.3%	-2.8%	-2.6%
6	6	ANTIHISTAMINES - 2ND GENERATION	44,306	-0.1%	-11.2%	29,719	6.5%	-2.3%	-11.5%
7	10	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	44,396	-1.3%	3.4%	29,385	6.4%	-1.5%	5.2%
8	9	IRON REPLACEMENT	38,355	-0.7%	0.5%	28,788	6.3%	-1.3%	0.8%
9	7	LAXATIVES AND CATHARTICS	42,626	-3.0%	-11.0%	28,320	6.2%	-4.0%	-11.2%
10	11	ANTIHYPERTENSIVES, ACE INHIBITORS	41,312	-1.3%	-2.5%	27,396	6.0%	-1.9%	-1.6%
11	8	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	37,911	-28.9%	-11.0%	26,728	5.8%	-32.9%	-12.9%
12	12	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	38,788	-0.5%	0.7%	25,982	5.7%	-0.9%	1.5%
13	13	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	23,477	0.0%	-1.9%	22,182	4.8%	0.4%	-1.4%
14	17	PRENATAL VITAMIN PREPARATIONS	24,125	-0.3%	9.1%	21,328	4.7%	-0.8%	9.9%
15	16	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	36,208	-3.0%	-3.7%	20,337	4.4%	-3.9%	-3.2%
16	14	TOPICAL ANTI-INFLAMMATORY STEROIDAL	23,070	-0.4%	-8.7%	20,006	4.4%	-0.5%	-8.5%
17	15	ANTIHISTAMINES - 1ST GENERATION	26,479	-6.7%	-8.4%	19,125	4.2%	-8.2%	-9.5%
18	20	INSULINS	31,514	-0.5%	-1.6%	18,050	3.9%	-1.4%	-0.9%
19	18	ANTIEMETIC/ANTIVERTIGO AGENTS	21,480	-8.6%	-8.6%	17,967	3.9%	-9.4%	-7.1%
20	19	GLUCOCORTICOIDS	20,639	-23.4%	-10.7%	16,719	3.6%	-26.6%	-11.2%

Table 5.3: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE ,SEROTONIN ANTAGNST	372,873	**1.4%**	**1.2%**	143,350	52.3%	**0.8%**	**0.6%**
2	2	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	101,046	**2.6%**	**3.5%**	43,929	16.0%	**1.8%**	**2.9%**
3	3	ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC	55,506	**0.7%**	**-1.0%**	21,896	8.0%	**0.1%**	**-2.2%**
4	7	NARCOTIC WITHDRAWAL THERAPY AGENTS	38,059	**9.3%**	**32.6%**	11,934	4.4%	**6.5%**	**26.5%**
5	4	BIPOLAR DISORDER DRUGS	28,080	**0.7%**	**-0.1%**	11,825	4.3%	**0.8%**	**-0.9%**
6	6	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	24,884	**0.8%**	**9.9%**	11,304	4.1%	**2.2%**	**12.4%**
7	5	INSULINS	22,583	**-1.3%**	**-2.6%**	11,267	4.1%	**-1.1%**	**-1.2%**
8	8	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	23,609	**1.4%**	**2.8%**	9,007	3.3%	**0.5%**	**0.3%**
9	10	ARV-NUCLEOSIDE,NUCLEOTIDE RTI,INTEGRASE INHIBITORS	16,870	**15.5%**	**32.3%**	7,331	2.7%	**16.4%**	**39.9%**
10	9	ANTICONVULSANTS	16,895	**0.4%**	**6.2%**	6,918	2.5%	**-1.0%**	**3.4%**
11	17	NARCOTIC ANTAGONISTS	8,077	**21.1%**	**62.9%**	5,733	2.1%	**21.4%**	**73.6%**
12	12	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	12,356	**-3.6%**	**8.1%**	5,217	1.9%	**-1.9%**	**10.3%**
13	11	ANTIPSYCHOTICS,PHENOTHIAZINES	12,572	**1.1%**	**-5.0%**	4,807	1.8%	**1.1%**	**-4.4%**
14	14	ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB	10,669	**-2.7%**	**3.6%**	4,338	1.6%	**-1.2%**	**5.6%**
15	16	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	8,552	**-4.2%**	**-10.5%**	3,546	1.3%	**-2.3%**	**-8.2%**
16	13	ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB	8,497	**-7.9%**	**-15.6%**	3,487	1.3%	**-8.0%**	**-16.2%**
17	19	ANALGESICS, NARCOTICS	5,824	**-3.3%**	**-1.9%**	2,948	1.1%	**-5.3%**	**-7.6%**
18	15	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	6,468	**-12.2%**	**-33.6%**	2,649	1.0%	**-12.11%**	**-32.4%**
19	18	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	5,227	**-7.0.%**	**-31.3%**	2,373	0.9%	**-5.7%**	**-27.9%**
20	21	ANTICONVULSANT - BENZODIAZEPINE TYPE	4,594	**-1.3%**	**15.3%**	2,050	0.8%	**-2.1%**	**14.8%**

Tables 6.1-6.3. Top 20 Drugs in the Medi-Cal Population.

This table presents utilization of the top 20 drugs, by **total utilizing beneficiaries.** The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of each drug is listed for reference.

Table 6.1: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	IBUPROFEN	77,510	-15.1%	-5.2%	68,630	9.4%	-15.4%	-5.4%
2	2	QUETIAPINE FUMARATE	139,464	0.4%	-0.2%	53,777	7.4%	-0.1%	-0.9%
3	3	ARIPIPRAZOLE	104,207	1.9%	2.0%	45,206	6.2%	1.1%	1.4%
4	4	ASPIRIN	53,650	-0.6%	-15.3%	36,901	5.1%	-1.1%	-13.6%
5	6	RISPERIDONE	83,244	0.5%	-2.0%	33,542	4.6%	-0.4%	-2.7%
6	5	AMOXICILLIN	34,683	-26.5%	-10.2%	31,842	4.4%	-26.9%	-10.4%
7	11	OLANZAPINE	78,569	1.3%	3.7%	30,282	4.2%	1.0%	3.4%
8	7	LORATADINE	44,032	-0.2%	-11.2%	29,641	4.1%	-2.4%	-11.6%
9	12	FERROUS SULFATE	39,452	-0.4%	0.4%	29,437	4.0%	-1.2%	0.7%
10	8	ALBUTEROL SULFATE	40,644	-29.4%	-11.3%	28,444	3.9%	-33.7%	-13.2%
11	13	METFORMIN HCL	41,181	-0.5%	0.8%	27,219	3.7%	-0.8%	1.5%
12	10	DOCUSATE SODIUM	39,327	-2.9%	-10.9%	26,431	3.6%	-3.8%	-11.3%
13	9	HYDROCODONE/ ACETAMINOPHEN	29,434	-6.6%	-20.1%	24,346	3.3%	-6.6%	-19.4%
14	14	CEPHALEXIN	23,889	-0.1%	-2.3%	22,531	3.1%	0.2%	-1.8%
15	15	BENZTROPINE MESYLATE	55,537	0.6%	-1.3%	21,891	3.0%	-0.3%	-2.3%
16	16	LISINOPRIL	32,859	-0.6%	0.1%	21,888	3.0%	-1.3%	1.0%
17	18	ATORVASTATIN CALCIUM	29,642	1.2%	14.3%	19,501	2.7%	0.9%	16.0%
18	19	LURASIDONE HCL	40,454	2.6%	5.3%	17,188	2.4%	2.0%	4.0%
19	20	FOLIC ACID	25,938	-1.8%	-4.2%	15,227	2.1%	-1.0%	-1.0%
20	17	ACETAMINOPHEN	15,277	-31.3%	-21.1%	14,268	2.0%	-30.2%	-20.8%

Table 6.2: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	IBUPROFEN	76.612	-15.1%	-5.0%	67,864	14.8%	-15.4%	-5.2%
2	2	ASPIRIN	52,625	-0.6%	-15.3%	36,313	7.9%	-1.0%	-13.4%
3	3	AMOXICILLIN	34,097	-26.5%	-10.1%	31,423	6.9%	-26.9%	-10.2%
4	4	LORATADINE	43,409	-0.4%	-11.3%	29,277	6.4%	-2.6%	-11.6%
5	8	FERROUS SULFATE	38,304	-0.7%	0.5%	28,760	6.3%	-1.3%	0.8%
6	5	ALBUTEROL SULFATE	37,916	-30.4%	-11.5%	27,145	5.9%	-34.2%	-13.4%
7	7	DOCUSATE SODIUM	38,847	-3.0%	-10.8%	26,096	5.7%	-3.9%	-11.2%
8	9	METFORMIN HCL	38,788	-0.5%	0.7%	25,982	5.7%	-0.9%	1.5%
9	6	HYDROCODONE/ ACETAMINOPHEN	28,850	-6.5%	-20.1%	23,834	5.2%	-6.6%	-19.3%
10	10	CEPHALEXIN	23,455	0.1%	-1.8%	22,165	4.8%	0.4%	-1.4%
11	11	LISINOPRIL	31,594	-0.6%	0.1%	21,204	4.6%	-1.2%	1.3%
12	13	ATORVASTATIN CALCIUM	29,231	1.3%	14.6%	19,268	4.2%	1.0%	16.7%
13	15	FOLIC ACID	25,305	-1.5%	-4.1%	14,850	3.2%	-0.8%	-0.9%
14	12	ACETAMINOPHEN	14,642	-31.7%	-21.8%	13,744	3.0%	-30.4%	-21.5%
15	17	AMLODIPINE BESYLATE	21,149	-1.2%	1.9%	13,583	3.0%	0.6%	5.0%
16	14	AZITHROMYCIN	14,334	-42.9%	-18.3%	13,258	2.9%	-43.4%	-18.4%
17	18	GABAPENTIN	22,478	-0.8%	3.0%	13,039	2.8%	-1.4%	2.5%
18	19	LEVOTHYROXINE SODIUM	21,490	-3.0%	-4.2%	12,450	2.7%	-3.4%	-2.1%
19	16	PREDNISONE	15,098	-16.3%	-8.6%	12,227	2.7%	-18.6%	-8.6%
20	20	PRENATAL VITS96/ IRON FUM/FOLIC	13,637	-0.1%	12.1%	12,069	2.6%	-0.2%	13.0%

Table 6.3: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q2 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	QUETIAPINE FUMARATE	128,223	**0.8%**	**0.2%**	49,464	18.0%	**0.3%**	**-0.6%**
2	2	ARIPIPRAZOLE	95,855	**2.0%**	**2.0%**	41,651	15.2%	**1.4%**	**1.4%**
3	3	RISPERIDONE	73,923	**0.8%**	**-1.4%**	29,911	10.9%	**-0.3%**	**-2.3%**
4	4	OLANZAPINE	70,553	**1.6%**	**4.3%**	27,163	9.9%	**1.1%**	**3.9%**
5	5	BENZTROPINE MESYLATE	50,769	**0.9%**	**-1.0%**	20,051	7.3%	**0.1%**	**-2.2%**
6	6	LURASIDONE HCL	38,065	**2.9%**	**5.9%**	16,184	5.9%	**2.6%**	**4.7%**
7	7	LITHIUM CARBONATE	27,781	**0.6%**	**-0.1%**	11,718	4.3%	**0.9%**	**-0.8%**
8	8	BUPRENORPHINE HCL/ NALOXONE HCL	32,041	**9.8%**	**34.9%**	9,676	3.5%	**6.9%**	**28.5%**
9	9	HALOPERIDOL	19,223	**1.2%**	**2.4%**	7,282	2.7%	**0.9%**	**-0.4%**
10	11	PALIPERIDONE PALMITATE	17,236	**6.0%**	**12.0%**	7,278	2.7%	**3.5%**	**13.7%**
11	12	EMTRICITABINE/ TENOFOVIR (TDF)	12,842	**4.3%**	**-3.7%**	6,388	2.3%	**5.1%**	**1.6%**
12	10	ZIPRASIDONE HCL	16,155	**-0.1%**	**-7.5%**	6,048	2.2%	**0.1%**	**-8.0%**
13	14	ELVITEG/COB/EMTRI/ TENOFOV ALAFEN	12,536	**-3.0%**	**14.2%**	5,213	1.9%	**-3.6%**	**19.5%**
14	17	EMTRICITABINE/ TENOFOV ALAFENAM	12,042	**-2.8%**	**22.7%**	4,916	1.8%	**-1.3%**	**30.4%**
15	13	INSULIN GLARGINE, HUM.REC. ANLOG	8,092	**-4.3%**	**-11.9%**	4,373	1.6%	**-3.5%**	**-8.7%**
16	15	INSULIN LISPRO	9,353	**0.4%**	**0.9%**	4,358	1.6%	**0.1%**	**2.4%**
17	16	ABACAVIR/ DOLUTEGRAVIR/LAMIVUDI	10,669	**-2.7%**	**3.5%**	4,338	1.6%	**-1.2%**	**5.6%**
18	18	DOLUTEGRAVIR SODIUM	9,862	**-2.5%**	**18.6%**	4,112	1.5%	**-1.1%**	**21.7%**
19	19	CLOZAPINE	18,296	**2.4%**	**3.6%**	3,251	1.2%	**1.6%**	**5.6%**
20	20	NALTREXONE HCL	5,365	**14.3%**	**25.3%**	3,203	1.2%	**12.9%**	**33.0%**

APPENDIX B: Definition of terms.

Adjudicate: To pay or deny drug claims after evaluating the claim for coverage requirements

Beneficiary: A person who has been determined eligible for Medi-Cal, as according to the California Code of Regulations 50024

Eligible beneficiary: A Medi-Cal beneficiary that qualifies for drug benefits

Quarter: One fourth, ¼, 25% or .25 of a year measured in months.

Drug therapeutic category: Drug therapeutic categories are grouping of drugs at various hierarchy levels and characteristics that may be similar in chemical structure, pharmacological effect, clinical use, indications, and/or other characteristics of drug products.

Utilizing beneficiary: A Medi-Cal beneficiary with at least one prescription filled during the measurement period

PHYSICIAN-ADMINISTERED DRUGS: 1st QUARTER 2018

Utilization of physician-administered drugs in the Medi-Cal Fee-for-Service program during the first quarter of 2018 (January – March 2018) is presented below, stratified by category. In order to show changes in utilization over time, **Table 1** shows the comparison to the prior quarter (2017 Q4) and **Table 2** shows the comparison to the prior-year quarter (2017 Q1).

Table 1: 2018 Q1 Physician-Administered Drugs: Change from 2017 Q4 (one quarter)

Category	Total Utilizing Beneficiaries	% Change from 2017 Q4	Total Paid Claims	% Change from 2017 Q4	Total Reimbursement Dollars Paid	% Change from 2017 Q4
PHYSICIAN ADMINISTERED DRUG - NDC NOT REQUIRED (vaccines, hyaluronate)*	62,696	**-16.6%**	172,102	**-9.3%**	$2,358,343	**-9.4%**
PHYSICIAN ADMINISTERED DRUG - NDC REQUIRED	248,242	**2.6%**	573,811	**0.7%**	$70,235,008	**9.4%**
MISCELLANEOUS PRODUCT - REPORTING REQUIRED (supplies, immune globulin, IV solutions)	119,460	**1.7%**	228,614	**1.2%**	$2,594,235	**0.7%**
TOTAL	430,398	**-0.9%**	974,527	**-1.1%**	$75,187,586	**8.4%**

Table 2: 2018 Q1 Physician-Administered Drugs: Change from 2017 Q1 (one year)

Category	Total Utilizing Beneficiaries	% Change from 2017 Q1	Total Paid Claims	% Change from 2017 Q1	Total Reimbursement Dollars Paid	% Change from 2017 Q1
PHYSICIAN ADMINISTERED DRUG - NDC NOT REQUIRED (vaccines, hyaluronate)*	62,696	**201.7%**	172,102	**434.5%**	$2,358,343	**145.6%**
PHYSICIAN ADMINISTERED DRUG - NDC REQUIRED	248,242	**-10.0%**	573,811	**-9.3%**	$70,235,008	**-3.0%**
MISCELLANEOUS PRODUCT - REPORTING REQUIRED (supplies, immune globulin, IV solutions)	119,460	**-4.9%**	228,614	**-10.7%**	$2,594,235	**-21.9%**
TOTAL	430,398	**2.0%**	974,527	**5.9%**	$75,187,586	**-1.9%**

*Effective July 1, 2017, Child Health and Disability Prevention (CHDP) claims processing officially transitioned to HIPAA compliant billing formats, including a change where providers are required to enter modifier SL (state-supplied vaccine) on vaccines supplied by the Vaccines for Children (VFC) program. While providers billing VFC procedure codes are reimbursed for vaccine administration costs only, these claims appear in the quarterly PADs data starting with 2017 Q3.

The following three tables show the top 20 physician-administered drugs by total utilizing beneficiaries (**Table 3**), total reimbursement dollars paid (**Table 4**), and reimbursement paid per utilizing beneficiary (**Table 5**). Each table has the comparison to the prior quarter and the prior-year quarter, for reference. In addition, the prior-year ranking is given to show changes in utilization of a drug over time.

Table 3: Top 20 Physician-Administered Drugs by *Total Utilizing Beneficiaries*								
Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q1 Total Utilizing Beneficiaries	% Change Total Utilizing Beneficiaries from 2017 Q4	% Change Total Utilizing Beneficiaries from 2017 Q1	2018 Q1 Total Reimbursement Dollars Paid	2018 Q1 Total Paid Claims
1	1	J3490	MEDROXYPROGESTERONE ACETATE	37,877	**1.5%**	**-7.6%**	$2,595,789	38,729
2	2	J3490	LEVONORGESTREL	30,157	**9.6%**	**4.5%**	$706,940	31,512
3	42	90670	PCV13 VACCINE IM*	25,232	**-2.2%**	**888.3%**	$270,870	26,954
4	3	S4993	LEVONORGESTREL -ETHIN ESTRADIOL	18,425	**5.2%**	**-14.0%**	$2,248,306	18,860
5	5	J1885	KETOROLAC TROMETHAMINE	17,657	**-2.5%**	**-0.9%**	$103,085	19,289
6	4	J2405	ONDANSETRON HCL/PF	16,331	**-14.0%**	**-18.6%**	$83,374	19,342
7	8	Z7610	ACETAMINOPHEN	15,584	**14.4%**	**31.3%**	$120,110	18,142
8	92	90680	RV5 VACC 3 DOSE LIVE ORAL*	12,899	**-20.2%**	**1369.1%**	$170,180	14,340
9	102	90744	HEPB VACC 3 DOSE PED/ADOL IM*	12,183	**-4.3%**	**1498.8%**	$111,666	12,466
10	11	J0696	CEFTRIAXONE SODIUM	11,253	**7.5%**	**0.8%**	$69,098	12,189
11	7	Q9967	LOCM 300399MG/ML IODINE,1ML	11,012	**-3.1%**	**-15.9%**	$50,870	11,774
12	9	Q0144	AZITHROMYCIN	10,774	**5.3%**	**-8.2%**	$256,345	11,181
13	6	J3490	ULIPRISTAL ACETATE	10,670	**8.4%**	**-29.1%**	$296,968	11,289
14	14	Z7610	IBUPROFEN	10,598	**10.4%**	**20.3%**	$79,502	11,148
15	10	J7307	ETONOGESTREL	9,749	**5.0%**	**-15.4%**	$7,527,658	9,749
16	13	S4993	NORGESTIMATE-ETHINYL ESTRADIOL	8,474	**6.0%**	**-14.7%**	$908,478	8,687
17	15	J1100	DEXAMETHASONE SODIUM PHOSPHATE	7,815	**3.8%**	**-3.5%**	$47,826	9,626
18	81	90648	HIB PRP-T VACCINE 4 DOSE IM*	7,711	**-30.7%**	**608.1%**	$73,778	8,211
19	12	J2270	MORPHINE SULFATE	7,618	**-16.0%**	**-24.0%**	$53,582	8,902
20	16	Z7610	HYDROCODONE/ACETAMINOPHEN	7,006	**-3.4%**	**-3.0%**	$71,186	7,734

*Effective July 1, 2017, Child Health and Disability Prevention (CHDP) claims processing officially transitioned to HIPAA compliant billing formats, including a change where providers are required to enter modifier SL (state-supplied vaccine) on vaccines supplied by the Vaccines for Children (VFC) program. While providers billing VFC procedure codes are reimbursed for vaccine administration costs only, these claims appear in the quarterly PADs data starting with 2017 Q3.

Table 4: Top 20 Physician-Administered Drugs by *Total Reimbursement Dollars Paid*								
Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q1 Total Reimburse-ment Dollars Paid	% Change Total Reimburse-ment Dollars from 2017 Q4	% Change Total Reimburse-ment Dollars from 2017 Q1	2018 Q1 Total Utilizing Beneficiaries*	2018 Q1 Total Paid Claims
1	1	J7307	ETONOGESTREL	$7,527,658	-18.7%	-14.7%	9,749	9,749
2	2	J7189	COAGULATION FACTOR VIIA,RECOMB (NOVOSEVEN®)	$5,011,068	-58.6%	0.6%	36	156
3	3	J7298	LEVONORGESTREL[1]	$2,875,290	-20.0%	-15.6%	3,975	3,975
4	6	J3490	MEDROXYPROGESTERONE ACETATE	$2,595,789	-8.4%	-4.3%	37,877	38,729
5	9	J1745	INFLIXIMAB	$2,492,232	0.9%	3.3%	541	1,051
6	10	Q4081	EPOETIN ALFA (100 UNITS ESRD)	$2,491,475	-0.5%	3.8%	1,992	44,244
7	4	J9355	TRASTUZUMAB	$2,347,074	-17.8%	-18.7%	254	808
8	12	90378	PALIVIZUMAB	$2,326,254	-45.7%	12.7%	422	1,103
9	8	S4993	LEVONORGESTREL-ETHIN ESTRADIOL	$2,248,306	-18.8%	-14.0%	18,425	18,860
10	7	J7300	COPPER INTRAUTERINE DEVICE	$2,139,341	-23.4%	-19.1%	3,206	3,229
11	16	J1300	ECULIZUMAB	$2,003,486	21.3%	44.3%	27	156
12	N/A	J1428	ETEPLIRSEN	$1,863,118	N/A	N/A	< 20	131
13	14	J7304	NORELGESTROMIN/ETHIN. ESTRADIOL	$1,812,255	12.0%	26.5%	3,057	3,132
14	15	J7192	ANTIHEMOPH.FVIII,FULL LENGTH (INCLUDES ADVATE®, HELIXATE®, AND KOGENATE®)	$1,689,715	28.2%	19.7%	54	273
15	5	J9019	ASPARAGINASE (ERWINIA CHRYSAN)	$1,685,187	1.4%	-41.4%	31	169
16	11	J2505	PEGFILGRASTIM	$1,655,518	-22.1%	-21.7%	252	510
17	13	J9306	PERTUZUMAB	$1,033,645	-24.4%	-32.0%	107	846
18	26	J1743	IDURSULFASE	$1,015,578	40.2%	47.0%	< 20	112
19	18	J7301	LEVONORGESTREL	$986,793	-23.3%	-23.7%	1,407	1,411
20	17	J9035	BEVACIZUMAB	$977,162	-28.6%	-24.6%	398	784

*Cells with numbers less than 20 have been changed for privacy

[1]Effective for dates of service on or after October 1, 2017, HCPCS codes J7297 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration) and J7298 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration) are benefits. Further, effective for dates of service on or after October 1, 2017, HCPCS code J7302 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg) is no longer reimbursable.

Table 5: Top 20 Physician-Administered Drugs by *Reimbursement Paid per Utilizing Beneficiary*								
Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q1 Reimburse-ment Dollars Paid per Utilizing Beneficiary	% Change Reimburse-ment Dollars Paid per Utilizing Beneficiary from 2017 Q4	% Change Reimburse-ment Dollars Paid per Utilizing Beneficiary from 2017 Q1	2018 Q1 Total Paid Claims*	2018 Q1 Total Utilizing Beneficiaries*
1	5	J7189	COAGULATION FACTOR VIIA,RECOMB (NOVOSEVEN®)	$139,196	**210.2%**	**39.7%**	156	36
2	2	J1322	ELOSULFASE ALFA	$123,706	**-23.0%**	**-3.7%**	61	< 20
3	3	J1458	GALSULFASE	$118,702	**7.0%**	**3.4%**	64	< 20
4	N/A	J1428	ETEPLIRSEN[1]	$103,507	**N/A**	**N/A**	131	< 20
5	1	J7181	FACTOR XIII A-SUBUNIT,RECOMB (TRETTEN®)	$101,626	**-15.8%**	**-26.0%**	< 20	< 20
6	N/A	J3590	CERLIPONASE ALFA[2]	$98,517	**10.0%**	**N/A**	22	< 20
7	4	J7185	ANTIHEMOPH.FVIII,B-DOMAIN DEL (XYNTHA®)	$95,004	**0.0%**	**-9.6%**	< 20	< 20
8	18	J7195	FACTOR IX HUMAN RECOMBINANT (BENEFIX®)	$92,800	**175.7%**	**151.5%**	< 20	< 20
9	10	J1743	IDURSULFASE	$92,325	**-4.7%**	**33.6%**	112	< 20
10	6	J7202	FACTOR IX RECOM,ALBUMIN FUSION (IDELVION®)[3]	$88,235	**278.8%**	**-3.9%**	< 20	< 20
11	N/A	C9028	INOTUZUMAB OZOGAMICIN[4]	$76,721	**N/A**	**N/A**	< 20	< 20
12	9	J1300	ECULIZUMAB	$74,203	**40.9%**	**1.5%**	156	27
13	11	J7205	ANTIHEMOPH.FVIII REC,FC FUSION (ELOCTATE®)[5]	$63,878	**13.3%**	**16.9%**	46	< 20
14	7	J9019	ASPARAGINASE (ERWINIA CHRYSAN)	$54,361	**-27.2%**	**-35.7%**	169	31
15	15	J7207	ANTIHEMO.FVIII,FULL LENGTH PEG (ADYNOVATE®)[6]	$50,912	**37.8%**	**19.3%**	24	< 20
16	8	J7201	FACTOR IX REC, FC FUSION PROTN (ALPROLIX®)	$45,165	**-45.4%**	**-44.4%**	< 20	< 20
17	33	J7198	ANTI-INHIBITOR COAGULANT COMP.	$42,762	**-47.9%**	**133.4%**	25	< 20
18	27	J0180	AGALSIDASE BETA	$41,962	**-2.7%**	**83.1%**	58	< 20
19	23	J7186	ANTIHEMOPHILIC FACTOR/VWF	$41,818	**66.6%**	**49.3%**	65	< 20
20	N/A	J9371	VINCRISTINE SULFATE LIPOSOMAL[7]	$32,598	**-38.9%**	**N/A**	< 20	< 20

*Cells with numbers less than 20 have been changed for privacy

[1]Code J1428 was effective retroactively for dates of service on or after September 1, 2016.
[2]Code J3590 was effective retroactively for dates of service on or after May 1, 2017.
[3]Code J7202 was effective January 1, 2018, however code J7199 was still accepted for this drug for part of 2018 Q1.
[4]Code C9028 was effective retroactively for dates of service on or after August 17, 2017.
[5]Code J7205 was effective October 1, 2017, replacing code Q9975.
[6]Code J7207 was effective January 1, 2018, however code C9137 was still accepted for this drug for part of 2018 Q1.
[7]Code J9371 did not have any utilizing beneficiaries in 2017 Q1.

CCS/GHPP DRUG UTILIZATION
MEDI-CAL FEE-FOR-SERVICE PROGRAM (2017)

Beneficiaries enrolled in either the California Children's Services (CCS) Program or the Genetically Handicapped Persons Program (GHPP) may be eligible for pharmacy benefits through the Medi-Cal fee-for-service program.

Drug utilization for these beneficiaries has not been reported previously. The following three tables show the top 20 drugs by total utilizing beneficiaries (**Table 1**), total reimbursement dollars paid to pharmacies (**Table 2**), and reimbursement paid per utilizing beneficiary (**Table 3**) for CCS/GHPP beneficiaries. Each table includes paid claims from the Medi-Cal fee-for-service program only.

Table 1: Top 20 CCS/GHPP Drugs by *Total Utilizing Beneficiaries*

Rank	Drug Description	2017 Total Utilizing Beneficiaries	2017 Total Reimbursement Dollars Paid to Pharmacies	2017 Total Paid Claims
1	INSULIN GLARGINE,HUM.REC.ANLOG	7,084	$14,579,580	38,054
2	INSULIN LISPRO	6,007	$28,190,197	40,196
3	GLUCAGON,HUMAN RECOMBINANT	5,540	$4,398,623	8,648
4	POLYETHYLENE GLYCOL 3350	3,623	$443,684	11,583
5	CHOLECALCIFEROL (VITAMIN D3)	3,515	$196,727	14,604
6	ALBUTEROL SULFATE	2,787	$831,716	13,376
7	LEVETIRACETAM	2,760	$1,274,681	17,856
8	LEVOTHYROXINE SODIUM	2,450	$334,238	15,293
9	SULFAMETHOXAZOLE/TRIMETHOPRIM	2,130	$193,450	7,224
10	INSULIN ASPART	2,100	$10,941,200	14,290
11	ENALAPRIL MALEATE	1,975	$3,428,788	10,105
12	CLOBAZAM	1,928	$23,375,796	15,174
13	BUDESONIDE	1,855	$5,202,653	9,675
14	RANITIDINE HCL	1,730	$529,019	6,621
15	METFORMIN HCL	1,714	$722,433	9,061
16	PEDI NUTRITION,IRON,LACT-FREE	1,710	$2,011,829	11,372
17	OXYCODONE HCL	1,637	$135,352	2,314
18	PREDNISONE	1,630	$135,726	7,640
19	ACETAMINOPHEN	1,558	$24,088	2,439
20	FUROSEMIDE	1,540	$76,971	5,260

Table 2: Top 20 CCS/GHPP Drugs by ***Total Reimbursement Dollars Paid***				
Rank	**Drug Description**	**2017 Total Reimbursement Dollars Paid to Pharmacies**	**2017 Total Utilizing Beneficiaries**	**2017 Total Paid Claims**
1	COAGULATION FACTOR VIIA,RECOMB	$115,259,252	55	526
2	ANTIHEMOPHIL.FVIII,FULL LENGTH	$108,742,337	514	4,721
3	NUSINERSEN SODIUM/PF	$38,041,797	85	268
4	ANTIHEMOPH.FVIII REC,FC FUSION	$36,609,518	98	1,140
5	SOMATROPIN	$34,607,245	1,141	7,667
6	INSULIN LISPRO	$28,190,197	6,007	40,196
7	DORNASE ALFA	$25,660,337	837	6,146
8	CLOBAZAM	$23,375,796	1,928	15,174
9	LUMACAFTOR/IVACAFTOR	$23,141,356	155	1,204
10	ANTIHEMOPHILIC FACTOR/VWF	$22,913,736	102	782
11	VIGABATRIN	$20,559,496	220	1,568
12	ADALIMUMAB	$19,931,770	556	3,665
13	ANTI-INHIBITOR COAGULANT COMP.	$19,759,927	23	339
14	ANTIHEMO.FVIII,FULL LENGTH PEG	$18,243,964	50	590
15	FACTOR IX REC, FC FUSION PROTN	$18,222,251	48	654
16	FACTOR IX HUMAN RECOMBINANT	$15,130,841	73	530
17	DEFERASIROX	$14,624,169	268	1,935
18	INSULIN GLARGINE,HUM.REC.ANLOG	$14,579,580	7,084	38,054
19	LIPASE/PROTEASE/AMYLASE	$14,533,353	890	6,271
20	SILDENAFIL CITRATE	$12,172,198	379	1,992

Table 3: Top 20 CCS/GHPP Drugs by ***Reimbursement Paid per Utilizing Beneficiary***				
Rank	**Drug Description**	**2017 Reimbursement Dollars Paid per Utilizing Beneficiary**	**2017 Total Utilizing Beneficiaries***	**2017 Total Paid Claims***
1	COAGULATION FACTOR VIIA,RECOMB	$2,095,623	55	526
2	ANTI-INHIBITOR COAGULANT COMP.	$859,127	23	339
3	SEBELIPASE ALFA	$597,680	<20	24
4	IDURSULFASE	$532,237	<20	105
5	PROTEIN C, HUMAN	$504,182	<20	79
6	LOMITAPIDE MESYLATE	$478,254	<20	28
7	NUSINERSEN SODIUM/PF	$447,551	85	268
8	PEGADEMASE BOVINE	$443,616	<20	25
9	INTERFERON GAMMA-1B,RECOMB.	$443,224	26	251
10	ALGLUCOSIDASE ALFA	$428,126	<20	<20
11	GLYCEROL PHENYLBUTYRATE	$423,661	28	284
12	FACTOR XIII A-SUBUNIT,RECOMB	$414,980	<20	65
13	ASFOTASE ALFA	$408,320	<20	51
14	FACTOR IX REC, FC FUSION PROTN	$379,630	48	654
15	ANTIHEMOPH.FVIII REC,FC FUSION	$373,567	98	1,140
16	ANTIHEMO.FVIII,FULL LENGTH PEG	$364,879	50	590
17	CYSTEAMINE BITARTRATE	$353,878	<20	117
18	ANTIHEMOPH.FVIII,B-DOM TRUNCAT	$328,789	22	270
19	ANTIHEMOPH.FVIII,B-DOMAIN DEL	$307,463	24	213
20	ELOSULFASE ALFA	$301,252	<20	105

*Cells with numbers less than 20 have been changed for privacy

UCSF School of Pharmacy

Retrospective DUR Updates: Q2 2018

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Retrospective DUR Updates – Q2 2018

Topic for Discussion

- Review of Retrospective DUR Criteria: Hypertension Medication Adherence

Hypertension Medication Adherence - 1

Objectives

- To assess adherence to hypertensive therapy among Medi-Cal beneficiaries
- To evaluate the use of home blood pressure monitoring devices among Medi-Cal beneficiaries

Hypertension Medication Adherence - 2

Methods

- Measurement period: 2017 (calendar year)
- Inclusion/Exclusion criteria:
  - Continuously-enrolled Medi-Cal beneficiaries not enrolled in Medicare at least 18 years of age during the measurement year with a diagnosis of hypertension (ICD-10-CM codes I10-I16)
  - At least two paid claims for an antihypertensive medication
  - At least 90 days of continuous treatment (with the first paid claim dated before September 30, 2017)

Hypertension Medication Adherence - 3

Methods (cont.)

- Classes of antihypertensive medications included:
  - Primary agents
    - thiazide or thiazide-type diuretics
    - angiotensin II receptor blockers [ARBs]
    - angiotensin converting enzyme [ACE] inhibitors
    - calcium channel blockers (CCBs)

Taken from the 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Hypertension Medication Adherence - 4

Methods (cont.)

- Classes of antihypertensive medications included:
  - Secondary agents
    - loop diuretics
    - potassium-sparing diuretics
    - aldosterone antagonist diuretics
    - beta blockers
    - direct renin inhibitor
    - alpha-1 blockers
    - central alpha2-agonists and other centrally acting drugs
    - direct vasodilators

Hypertension Medication Adherence - 5

Methods (cont.)

- Adherence measured using proportion of days covered (PDC)
  - PDC = Total number of days beneficiary was covered by at least one antihypertensive medication drug/Total number of days in the treatment period
  - Treatment period and days covered based on the prescription fill dates and days of supply
  - PDC greater than or equal to 80% is considered adherent for antihypertensive medications

Hypertension Medication Adherence - 6

Methods (cont.)

- Medical claims data from the study population were reviewed for paid claims for home blood pressure monitoring devices
  - HCPCS codes: A4670, A4660, A4663
- Claims data from January 1, 2012, through December 31, 2017 were reviewed

Hypertension Medication Adherence - 7

Drug Class	Study Population	ICD10 for Hypertension
thiazide or thiazide-type diuretics		4,343
angiotensin II receptor blockers [ARBs]		3,400
angiotensin converting enzyme [ACE] inhibitors		10,380
calcium channel blockers (CCBs)		5,826
loop diuretics		2,144
potassium-sparing diuretics		< 20
aldosterone antagonist diuretics		700
beta blockers		7,391
direct renin inhibitor	< 20	< 20
alpha-1 blockers		606
central alpha2-agonists and other centrally acting drugs		1,124
direct vasodilators		655

Hypertension Medication Adherence - 8

Results:
% of population adherent
(≥ 80% PDC)

Drug Class	Study Population	ICD10 for Hypertension
thiazide or thiazide-type diuretics	21.7%	36.6%
angiotensin II receptor blockers [ARBs]	38.1%	44.7%
angiotensin converting enzyme [ACE] inhibitors	33.4%	42.4%
calcium channel blockers (CCBs)	34.2%	40.5%
loop diuretics	23.1%	34.4%
potassium-sparing diuretics	19.8%	
aldosterone antagonist diuretics	24.8%	39.9%
beta blockers	20.4%	32.8%
direct renin inhibitor		
alpha-1 blockers	35.8%	44.5%
central alpha2-agonists and other centrally acting drugs	31.5%	37.6%
direct vasodilators	25.5%	32.1%

Hypertension Medication Adherence - 9

Results

- Adherence rates were higher when the beneficiary had a documented ICD10 code for hypertension
- Adherence rates were low, even in comparison to other studies that evaluated adherence to antihypertensive in the Medicaid population

Hypertension Medication Adherence - 10

Results: Home blood pressure monitoring devices

Year	Utilizing Beneficiaries	Total Paid Claims
2012	64	121
2013	739	1,561
2014	656	1,237
2015	867	1,668
2016	1,359	2,637
2017	2,815	5,320

Steady increase over time

Hypertension Medication Adherence - 11

Results

- Having a paid claim for an HBPM was not correlated with greater adherence to antihypertensive medications

Hypertension Medication Adherence - 12

Discussion/Conclusion

- Adherence to antihypertensive medications was low
- Paid claims for home blood pressure monitoring are increasing
- Recommend DUR educational bulletin to providers
  - Summary of the 2017 ACC/AHA Guidelines, including a ist of primary and secondary agents on the Medi-Cal FFS CDL
  - Evaluation of adherence rates in the Medi-Cal population
  - Provide recommendations for prescribers and pharmacists to improve adherence to antihypertensive medications

Board recommendations?

Future Topics: Retrospective Reviews

- Annual review of drugs added to the Medi-Cal List of Contract Drugs (ongoing, presented each November)
- HCV medications (ongoing, presented each November)
- Pharmacist furnishing of hormonal contraceptives
- Assessment of opioid use and mortality (stratified by gender)

Future Topics: Adult Core Set Measures

- 2018 Adult Core Set Measures:
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
  - Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
  - Concurrent Use of Opioids and Benzodiazepines (COB-AD)
  - Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)

Future Topics: Child Core Set Measures

- 2018 Child Core Set Measures:
  - Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
  - Asthma Medication Ratio: Ages 5–18 (AMR-CH)
  - Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)

Board recommendations?

UCSF School of Pharmacy

Summary of Activities: DUR Publications

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DUR Publications

July 2018

- Alert – Drug Safety Communication: Adverse Effects from Fluoroquinolone Antibiotics

- Bulletin – ProDUR Update: Additive Toxicity Alert Now Focused Only On CNS Depressants

Updates to Existing Publications

- QT-Prolongation Bulletin (published August 2017):
  - Previous Clinical Recommendation:
    - An ECG should be routinely checked before and after starting QT-prolonging medication.
  - Updated Clinical Recommendation:
    - Before and after starting a new QT-prolonging medication, providers should consider whether an ECG is indicated based on both the potential of the medication to cause QT prolongation and individual risk factors for the patient (for example, personal history of QT prolongation, potential for drug interactions). Consider checking a source such as the CredibleMeds website to review the potential of medications to result in QT-prolongation.

Other Updates

- Disclaimer added to website and future publications:
  - *“These articles are the result of analyses carried out by the Global Medi-Cal DUR Program and are not official policies of the Department of Health Care Services (DHCS).”*

Future Recommendations

- Alerts:
  - Mandatory CURES consultation (submitted for September publication)
  - California Upgrades Immunization Registry to CAIR2
- Bulletins:
  - Annual vaccine bulletin (submitted for September publication)
  - Latent tuberculosis infection (submitted for September publication)
  - Managing pain in population with comorbid mental health conditions
  - Pharmacist furnishing of naloxone, hormonal contraception
  - Today's meeting topic: hypertension medication adherence

Board recommendations?

MEDICAID MANAGED CARE ORGANIZATION DRUG UTILIZATION REVIEW ANNUAL REPORT

COMPANION GUIDE

Disclaimer

This Companion Guide is based on questions from managed care plans and past experience in completing the CMS DUR Annual Report. We suggest Managed Care Plans always follow all applicable laws, CMS official guidance and updates.

Version 1.1

Purpose of this Guide

Section 438.3 (s)(4) requires managed care plans that provide coverage of covered outpatient drugs to also operate a Drug Utilization Review (DUR) program that complies with the requirements at 1927 (g) of the Act.

Section 438.3(s)(5) requires managed care plans to provide a detailed description of its DUR program activities to the state on an annual basis.

The purpose of the DUR Annual report is to ensure that managed care plans (MCOs, PIHPs and PAHPs*) meet the parameters of section 1927 (g) of the Act.

This companion guide is to support managed care plans to complete the annual report and submit to DHCS on a timely basis. The content of this document will be subject to continuous updates.

*MCO, PIHP, PAHP are collectively referred to as Managed Care Plans or MCOs.

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We thank the Global Medi-Cal DUR Board, the DUR team (DHCS, Conduent, UCSF) and Managed Care Health Plans Pharmacy Directors and associates for providing guidance in the preparation of this document.

September 1, 2018

Table of Contents

Introduction

The DUR Program promotes patient safety through state-administered utilization management tools and systems that interface with the Medicaid Management Information Systems (MMIS). It is a two-phase process. In the first phase, Prospective DUR, the state's Medicaid agency's electronic monitoring system screens prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. In the second phase, Retrospective DUR, there is ongoing and periodic examination of claims data to ensure quality of care, identify patterns of fraud, abuse, gross overuse, or medically unnecessary care. When appropriate, corrective actions are implemented.

42 CFR 438.3(s)(4)and(5) require that each Medicaid managed care organization (MCO) must operate a DUR program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities to the state. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care.

The initial report covers the period October 1, 2017 to September 30, 2018.

Global Medi-Cal DUR Board

On May 10, 2017, DHCS published an All Plan Letter (APL) 17-008 to establish requirements to participate in the Medi-Cal DUR Program. The purpose of this APL is to clarify Medi-Cal managed care health plans' (MCOs') contractual requirements related to Medi-Cal drug utilization requirements pursuant to Title 42, Code of Federal Regulations (CFR), Section 438.3(s).

Effective July 1, 2017, in collaboration with DHCS Fee-For-Service (FFS) Program for covered outpatient drugs, MCOs shall participate in a Global Medi-Cal DUR program.

Global DUR Board Meetings for Federal Fiscal Year: October 1, 2017 to September 30, 2018
November 28, 2017
March 6, 2018
May 22, 2018
September 18, 2018

Annual Report

Each MCO is required to prepare an MCO-specific annual report to identify MCO DUR activities that occur outside of the Global DUR.

The annual report for federal fiscal year 2018 covers the period October 1, 2017 to September 30, 2018. The report is due to DHCS on April 1, 2019.

The form to use is OMB approved #0938-0659.

I. Demographic Information

MCO Name:

Medicaid MCO Information:

Identify your MCO person responsible for DUR Annual Report Preparation.

1. On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

• Report only Medi-Cal (California Medicaid) beneficiaries for this survey. • Reporting period is Federal Fiscal Year 2018 (October 1, 2017 through September 30, 2018). • Report average monthly enrollment.

II. Prospective DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.
   - State-operated
   - Contractor, please identify name
   - Other organization, please identify name

• Select either Contractor or other organization. For California, state-operated refers to Medi-Cal, the Department of Health Care Services (DHCS). • If your POS is a vendor (example is a Pharmacy Benefits Manager or PBM, select "Contractor, and identify name of vendor) • If your MCO operates POS, and does not contract with a vendor, select "other organization, and identify name of MCO.

2. Identify prospective DUR criteria source.
   - First Data Bank
   - Medi-Span
   - Other, please specify

3. Who reviews your new prospective-DUR criteria?
   - MCO's DUR Board
   - FFS agency DUR Board
   - Other, please explain

For the purposes of this survey, if a vendor or a contractor reviews, choose "Other" and explain the type of vendor or contractor performing this function, or provide any other applicable explanation.

4. Are new ProDUR criteria approved by the DUR Board?
    - Yes
    - No, please explain

5. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?

> Level-one alerts are those of the highest significance. If your plan uses a combination of hard rejects, soft rejects, and message only alerts for level-one ProDUR alerts, please chose "Partial" and explain the criteria allowing pharmacist to override the alerts.

    - Yes
    - No
    - Partial, please explain.

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider override activity in summary and/or in detail?
    - Yes
    - No, please explain.

    If the answer to question 6 is "No," skip to question 7.
    If the answer to question 6 is "Yes," please continue below.

    a. How often do you receive reports?
        - Monthly
        - Quarterly
        - Annually
        - Other, please explain.

    b. Do you follow up with those providers who routinely override with interventions?
        - Yes
        - No, please explain.

        If the answer to question 6b is "No," skip to question 7.
        If the answer to question 6b is "Yes," please continue below.

    c. By what method do you follow up?
        - Contact Pharmacy
        - Refer to Program Integrity for Review
        - Other, please explain.

> Program Integrity: Combating Medicaid provider fraud, waste, and abuse, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid enrollees.

7. Early Refill
    - At what percent threshold do you set your system to edit?

        Non-controlled drugs ____ %

        Schedule II controlled drugs ____ %

        Schedule III through V controlled drugs ____%

    - **For non-controlled drugs:**

    When an early refill message occurs, does your MCO require prior authorization?

    - Yes
    - No

    If the answer to question 7b is "Yes," who obtains authorization?

        - Pharmacist
        - Prescriber
        - Both

    If the answer to question 7b is "No," can the pharmacist override at the point of service?

        - Yes
        - No

    - **For controlled drugs:**

    When an early refill message occurs, does your MCO require prior authorization?

    - Yes
    - No

    If the answer to question 7c is "Yes," who obtains authorization?

    - Pharmacist
    - Prescriber
    - Both

If the answer to question 7c is "No," can the pharmacist override at the point of service?

- Yes
- No

8. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your MCO's policy allow the pharmacist to override for situations such as:
    - Lost/stolen Rx
    - Vacation
    - Other, please explain.

    Note: There is no word limit to write the explanation. It is acceptable to use bullet points to explain.

9. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?
    - Yes
    - No

    If "Yes," please explain your edits.

    If "No," do you plan to implement this edit?

    - Yes
    - No

10. Does the MCO have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?
    - Yes
    - No

11. Does your MCO have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled chronic medication refills at the same time, your MCO would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?
    - Yes
    - No

12. For drugs not on your MCO's formulary, does your MCO have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?
    - Yes
    - No

If "Yes," what is the preauthorization process?

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

13. Please list the requested data in each category in *Table 1 – Top Drug Claims Data Reviewed by the DUR Board* below.

The table below does not have a word limit.

Table 1: Top Drug Claims Data Reviewed by the DUR Board Fee-For-Service Example:

Top 10 PA Requests by Drug Name	Top 10 PA Requests by Drug Class	Top 5 Claim Denial Reasons (i.e. QL, Early Refill, PA, Duplication)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid	Top 10 Drug Names by Claim Count	Drugs By Claim Count % of Total Claims
ARIPIPRAZOLE	SECOND GENERATION ANTI-PSYCHOTICS	Claim requires an approved Treatment Authorization Request (TAR) due to beneficiary age	ARIPIPRAZOLE	12.9%	QUETIAPINE FUMARATE	4.9%
PALIPERIDONE PALMITATE	OPIOID ANALGESICS AND COMBINATIONS	Claim requires an approved TAR due to exceeding quantity limits, days supply, and/or frequency	LURASIDONE HCL	5.3%	ARIPIPRAZOLE	3.6%
RISPERIDONE	CNS STIMULANTS	Claim requires an approved TAR because claim exceeds the 6 prescription limit	PALIPERIDONE PALMITATE	4.1%	IBUPROFEN	3.0%

III. Retrospective DUR (RetroDUR)

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) agency or does your MCO have its own DUR Board?

    - Same DUR Board as FFS agency
    - MCO has its own DUR Board
    - Other, please explain.

    > Select "other", since the Global DUR Board does not perform all RetroDUR for each MCO. Include an explanation of your MCO's participation in the same DUR Board as FFS agency, as well as whether your MCO has a pharmacy and therapeutics (P&T) committee or equivalent body, that oversees the performance of DUR functions within the MCO.

2. Identify the entity, by name and type, that performed your RetroDUR activities during the time period covered by this report (company, academic institution, other organization, or indicate if your MCO executed its own RetroDUR activities).

    > If your MCO utilizes a PBM to perform RetroDUR, identify the entity, by name and type. Answer accordingly if an academic institution, other organization, or if your MCO executed its own RetroDUR.

3. Who reviews and approves the RetroDUR criteria?
    - State DUR Board
    - MCO DUR Board
    - Other, please explain.

    > If your MCO utilizes a PBM to perform RetroDUR, identify the entity (PBM), by name and type. Answer accordingly if an academic institution, other organization, or if your MCO performs its own RetroDUR.

4. Has your MCO included Attachment 1 – Retrospective DUR Educational Outreach Summary, a year end summary of the Top 10 problem types for which education interventions were taken?
    - Yes
    - No

Educational Bulletin Fee-For-Service Example:

Drug Safety Communication: Risks of Codeine and Tramadol Use in Children – May 2017

Summary: This alert described a recent drug safety communication from the FDA announcing that they are restricting the use of codeine and tramadol medicines in children. They also recommend against the use of codeine and tramadol medicines in breastfeeding mothers due to possible harm to their infants.

Recommendations:

1. Health care providers should be aware that tramadol and single-ingredient codeine medicines are FDA-approved only for use in adults.
2. Over-the-counter (OTC) or other FDA-approved prescription medicines should be considered for pain management in children younger than 12 years of age and in adolescents younger than 18 years of age, especially those with certain genetic factors, obesity, or obstructive sleep apnea and other breathing problems.

Provider Intervention Letter Fee-For-Service Example:

Fluoroquinolone Letter – August 2017

Objectives:

- To inform providers of the FDA-approved safety labeling changes for fluoroquinolones
- To decrease the number of Medi-Cal patients receiving treatment with fluoroquinolones for acute bacterial exacerbation of chronic bronchitis, acute sinusitis, and uncomplicated UTI

Methods: The top 100 prescribers (by total number of paid claims prescribed) of fluoroquinolones in the Medi-Cal fee-for-service program between January 1, 2017 and June 30, 2017 were sent a letter with information about the FDA recommendations for fluoroquinolone use. The mailing also included the following:

- Medi-Cal DUR article on fluoroquinolones
- Provider response survey

Outcomes: A response rate of 10% was noted within 90 days of the mailing. As stated in the original proposal, the primary outcome variable will be the percentage decrease in the number of paid claims for fluoroquinolone among prescribers who received the mailing, assessed one year after the DUR mailing (paid claims between January 1, 2018, and June 30, 2018). Additional outcomes will be evaluated after the data are complete and will be presented to the DUR Board at that time.

IV. DUR Board Activity

1. Has your MCO included a brief summary of DUR Board activities during the time period covered by this report as **Attachment 2 -Summary of DUR Board Activities**?
    - Yes
    - No

If your MCO does not have a DUR Board, but performs some DUR functions, indicate the name of the committee(s) and/or vendor carrying out the DUR activities. Use Attachment 2 to include a summary. The Global DUR Board Meeting MCP Actions lists a summary of required actions for RetroDUR and Educational Bulletins. Add only those items your MCO has taken action, and include the name, date, and method of dissemination. Also, include your MCOs DUR activities that occurred outside of the actions of the Global DUR Board.

Attachment 2 – Summary of DUR Board Activities

This summary should be a brief descriptive report on DUR Board activities during the fiscal year reported. This summary should:

- Indicate the number of DUR Board meetings held.

List your MCO's or delegated vendor's DUR committee meeting dates outside of the Global DUR Board meetings.

- List additions/deletions to DUR Board approved criteria
    - For prospective DUR, list problem type/drug combinations added or deleted.

Please note that some functions of a MCOs ProDUR program may be implemented under contract by a MCO's PBM. In addition, some MCOs may implement their DUR programs under the auspices of their P&T committees.

    - For retrospective DUR, list therapeutic categories added or deleted

Please note that some functions of a MCOs RetroDUR program may be implemented under contract by a MCP's PBM. In addition, some MCPs may implement their DUR programs under the auspices of their P&T committees.

- Describe Board policies that establish whether and how results of prospective DUR screenings are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screenings are used to adjust prospective DUR screens.

- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

Provider-specific Interventions

Educational articles and alerts:

- Article: Drug Safety Communication: New Age Limit for Opioid Cough and Cold Medicines – February 28, 2018
- Article: In the Pharmacy: Pharmacists Furnishing Nicotine Replacement Products – March 30, 2018
- Article: Drug Safety Communication: Adverse Effects from Fluoroquinolone Antibiotics – July 31, 2018
- Article: ProDUR Update: Additive Toxicity Alert Now Focused Only On CNS Depressants – July 31, 2018

2. Does your MCO have a Medication Therapy Management Program?
    - Yes
    - No

If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a. Have you performed an analysis of the program's effectiveness?
    - Yes, please provide a brief summary of your findings.
    - No

b. Is your DUR Board involved with this program?
    - Yes
    - No

If the answer to question 2 is "No," are you planning to develop and implement a program?

- Yes
- No

V. Physician Administered Drugs

The Deficit Reduction Act required collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?
    - ○ Yes
    - ○ No

    If "No," do you have a plan to include this information in your DUR criteria in the future?

    - ○ Yes
    - ○ No

2. RetroDUR?

    - ○ Yes
    - ○ No

    If "No," do you have a plan to include this information in your DUR criteria in the future?

    - ○ Yes
    - ○ No

VI. Generic Policy and Utilization Data

1. Has your MCO included a brief description of policies that may affect generic utilization percentage as **Attachment 3 – Generic Drug Substitution Policies**?
    a. Yes
    b. No
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your MCO have a more restrictive requirement?
    a. Yes
    b. No

    If "Yes," check all that apply:

    - ☐ Require that a MedWatch Form be submitted
    - ☐ Require the medical reason(s) for override accompany the prescription
    - ☐ Prior authorization is required
    - ☐ Prescriber must indicate "Brand Medically Necessary" on the prescription
    - ☐ Other, please explain

Generic Utilization Percentage
To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

N ÷ (S + N + I) × 100 = Generic Utilization Percentage

- **Single Source (S)** – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.
- **Non-Innovator Multiple-Source (N)** – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market.
- **Innovator Multiple-Source (I)** – Drugs which have an NDA and no longer have patent exclusivity**.**

Table 2: Generic Drug Utilization Data Fee-For-Service Example:

Single-Source (S) Drugs		Non-Innovator (N) Drugs		Innovator Multi-Source (I) Drugs	
Total Number of Claims	1,690,783	Total Number of Claims	7,970,088	Total Number of Claims	1,025,520

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in *Table 2 – Generic Utilization Data.*

   Number of Generic Claims: _____
   Total Number of Claims: _____
   Generic Utilization Percentage: _____

Table 2: Generic Drug Utilization Data Fee-For-Service Example:

Number of Generic Claims: 7,970,088
Total Number of Claims: 11,380,709
Generic Utilization Percentage: 70.0%

VII. Fraud, Waste, and Abuse Detection

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?
   - ○ Yes
   - ○ No

If "Yes," what actions does this process initiate? Check all that apply:

- ☐ Deny claims and require prior authorization
- ☐ Refer to Lock-In Program
- ☐ Refer to Program Integrity Unit
- ☐ Other (i.e. SURS, Office of Inspector General), please explain

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances?
   - ○ Yes
   - ○ No

If the answer to question 2 is "No," skip to question 3.

If the answer to question 2 is "Yes," please continue with questions a), b), c) and d) below.

a. What criteria does your MCO use to identify candidates for Lock-In? Check all that apply:
   - ☐ Number of controlled substances (CS)
   - ☐ Different prescribers of CS
   - ☐ Multiple pharmacies
   - ☐ Number days' supply of CS
   - ☐ Exclusivity of short acting opioids
   - ☐ Multiple ER visits
   - ☐ PDMP data
   - ☐ Same FFS state criteria is applied
   - ☐ Other, please explain

b. Do you have the capability to restrict the beneficiary to:
   i. prescriber only
      - ○ Yes
      - ○ No

ii. pharmacy only
   - Yes
   - No

iii. prescriber and pharmacy only
   - Yes
   - No

c. What is the usual Lock-In time period?
   - 12 months
   - 18 months
   - 24 months
   - Other, please explain

d. On average, what percentage of your Medicaid MCO population is in Lock-In status annually? _____%

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?
   - Yes
   - No

   If "Yes," what actions does this process initiate? Check all that apply:
   - ☐ Deny claims written by this prescriber
   - ☐ Refer to Program Integrity Unit
   - ☐ Refer to the appropriate Medical Board
   - ☐ Other, please explain

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?
   - Yes
   - No

   If "Yes," what actions does this process initiate? Check all that apply:
   - ☐ Deny claims written by this prescriber
   - ☐ Refer to Program Integrity Unit
   - ☐ Refer to the appropriate Medical Board
   - ☐ Other, please explain

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by **beneficiaries**?

- Yes, please explain your program for fraud, waste or abuse of non-controlled substances.
- No

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Do you require prescribers (in your provider agreement with your MCO) to access the PDMP patient history before prescribing controlled substances?
    - Yes, please explain how the MCO applies this information to control fraud and abuse.
    - No
    - No, the state does not have a PDMP

2. Does your MCO have the ability to query the state's PDMP database?
    - Yes
    - No

If "Yes," are there barriers that hinder your MCO from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

- Yes, please explain the barriers that exist
- No

C. PAIN MANAGEMENT CONTROLS

1. Does your MCO obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?
    - Yes
    - No

If the answer to question 1 is "No," skip to question 2 below.

If the answer to question 1 is "Yes," please continue.

Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

- Yes
- No

If *"Yes,"* please explain how information is applied.

If *"No,"* do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

- Yes
- No

2. Do you apply this DEA file to your RetroDUR reviews?
    - Yes, please explain how it is applied.
    - No

> This is a complete authorized DEA database of persons and organizations certified to handle controlled substances under the Controlled Substances Act (CSA). DEA authorizes the use of this database, and the inclusion of any individual or organization in the database, as proof of that entity's registration with the DEA. The database is used to credential practitioners as well as to certify a practitioner s CSA status and is extremely useful to HMOs, clinics, health insurance, pharmaceutical, and medical services firms, and others who must verify that a practitioner is registered to handle controlled substances.
>
> It is the MCO's responsibility to ensure that their providers who prescribe controlled medications have an active DEA registration. This file can be used to verify that a registration is active.

3. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?
    - Yes
    - No, please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

D. OPIOIDS

1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?
    - Yes for all opioids
    - Yes for some opioids
    - No for all opioids

If the answer to question 1 is "No," skip to question 2.

If the answer to question 1 is "Yes for all opioids" or "Yes for some opioids," please continue with questions a), b) and c) below.

a) Is there more than one quantity limit for the various opioids?
    - Yes, please explain.
    - No

b) What is your maximum number of days allowed for an initial opioid prescription? _____ days

c) Does the above initial day limit apply to all opioid prescriptions?
    - Yes, please explain.
    - No

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?
   - Yes
   - No

   If "Yes," what is your maximum days supply per prescription limitation?

   - 30 day supply
   - 90 day supply
   - Other, please explain.

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?
   i. Yes
   ii. No

   If "Yes," what is your maximum days supply per prescription limitation?

   - 30 day supply
   - 90 day supply
   - Other, please explain.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

   a. Yes
   b. No

   If "Yes," please check all that apply:

   - ☐ Pharmacist override
   - ☐ Deny claim and require PA
   - ☐ Intervention letters
   - ☐ Morphine equivalent daily dose (MEDD) program
   - ☐ Step therapy or clinical criteria
   - ☐ Requirement that patient has a pain management contract or Patient-Provider agreement
   - ☐ Requirement that prescriber has an opioid treatment plan for patients
   - ☐ Require documentation of urine drug screening results
   - ☐ Other, please explain what additional opioid prescribing controls are in place.

   If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

   a. Yes, please explain
   b. No

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

   a. Yes
   b. No

If the answer to question 6 is "Yes," please indicate how often:

- Monthly
- Quarterly
- Semi-Annually
- Annually
- Other, please explain.

If the answer to question 6 is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis or history of OUD or opioid poisoning in the future?

a. Yes
b. No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?
   - Yes
   - No

   For either "Yes" or "No," please check all that apply:

   - ☐ Your MCO refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain. Please identify the "referred" guidelines.
   - ☐ Other guidelines, please identify
   - ☐ No guidelines are offered

8. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

a. Yes, please explain
b. No

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?
   a. Yes
   b. No

If the answer to question 1 is "Yes," please continue with questions a) and b) below.

a) What is your maximum morphine equivalent daily dose limit in milligrams? _____ mg per day

b) Please explain (i.e. are you in the process of tapering patients to achieve this limit?)

If the answer to question 1 is "No," please explain the measure or program you utilize.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?
   - Yes
   - No

If the answer to question 2 is "No," skip to question 3.
If the answer to question 2 is "Yes," please continue with questions a) and b) below.

a) Please name the developer of the calculator.

b) How is the information disseminated? Check all that apply:
   - ☐ Website
   - ☐ Provider notice
   - ☐ Educational seminar
   - ☐ Other, please explain

3. Do you have an edit in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?
   - Yes
   - No

If "Yes," do you require prior authorization if the MEDD limit is exceeded?

- Yes
- No

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

1. Does your MCO set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?
   - Yes
   - No

If these drugs are carved-out of your MCO, select "No."

If "Yes," please specify the total mg/day:

- 12 mg
- 16 mg
- 24 mg
- Other, please explain

2. What are your limitations on the allowable length of this treatment?
   - 6 months
   - 12 months
   - No limit
   - Other, please explain

For carved-out drugs, select "Other" and indicate carved-out drugs

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?
   - Yes
   - No

If "Yes," please continue with questions a) and b) below.

a) What is your reduced (maintenance) dosage?
   - 8 mg
   - 12 mg
   - 16 mg
   - Other, please explain

b) What are your limitations on the allowable length of the reduced dosage treatment?
    - 6 months
    - 12 months
    - No limit
    - Other, please explain

4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?
    - Yes
    - No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?
    - Yes
    - No
    - Other, please explain

Even for carved-out buprenorphine-containing products, MCOs can have edits and policies in place to monitor concurrent opioid use.

If "Yes," can the POS pharmacist override the edit?

    - Yes
    - No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?
    - Yes
    - No

7. Does your MCO allow pharmacists to dispense naloxone prescribed independently, or by collaborative practice agreements, or standing orders, or other predetermined protocols?
    - Yes
    - No
8. Does your MCO cover methadone for OUD (i.e. Methadone Treatment Center)?
    - Yes
    - No

G. ANTIPSYCHOTICS /STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

> For question 1, if your plan has antipsychotics carved out, select "No" and explain these drugs are carved out.
>
> For question 2, select "yes" if plan has a documented program in place to either manager or monitor, whether it is carved out or not.

   - Yes
   - No, please explain

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?
   - Yes
   - No

   If "Yes," please continue with questions a), b) and c) below.

   a) Do you either manage or monitor:
      - Only children in foster care
      - All children
      - Other, please explain

   b) Do you have edits in place to monitor (check all that apply):
      - ☐ Child's Age
      - ☐ Dosage
      - ☐ Polypharmacy
      - ☐ Other, please explain

   c) Please briefly explain the specifics of your antipsychotic monitoring program(s).

   If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

      - Yes
      - No, please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

1. Do you currently have restrictions in place to limit the quantity of stimulants?
   - Yes

- No

2. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?
    - Yes
    - No

    If the answer to question 4 is "Yes," please continue with questions a), b) and c) below.

    a) Do you either manage or monitor:
        - Only children in foster care
        - All children
        - Other, please explain

    b) Do you have edits in place to monitor (check all that apply):
        - ☐ Child's Age
        - ☐ Dosage
        - ☐ Polypharmacy

    c) Please briefly explain the specifics of your documented stimulant monitoring program(s).

    If the answer to question 4 is "No," that is you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

        - Yes
        - No, please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

VIII. Innovative Practices

Attachment 4 – Innovative Practices

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value-Based Purchasing)? Please describe in detailed narrative form any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e. disease management, academic detailing, automated prior authorizations, continuing education programs).

Innovative Practices Fee-For-Service Example:

1. Improve psychotropic medication use for children and youth: In collaboration with the California Department of Social Services and the Department of Health Care Services, the DUR Board aims to improve safe and appropriate prescribing and monitoring of psychotropic medication use for all children and adolescents, including those in foster care. The DUR Board advises and provides recommendations regarding draft guidelines for improving oversight and monitoring of psychotropic medication use for children and youth and optimal prescribing standards to engage prescribers to use minimum number of psychotropic medications, at the lowest appropriate dosage and at the appropriate age.

   In FFY 2017, the state of California continued to participate in the CMS Antipsychotic Drug Use in Children (ADC) Affinity Group. This represented a collaborative effort between the DUR Board and other state agencies, including the Department of Health Care Services. The goal of the ADC Affinity Group was to focus on strategies to improve the quality of care for children who are prescribed antipsychotic drugs. CMS supported California's efforts to improve quality of care by providing learning opportunities, regular meetings and communications between states. Quarterly group calls were held with other states and Quality Improvement (QI) experts. Activities of the ADC Affinity Group were shared with the DUR Board at each meeting and input from the Board was welcome. With the support of CMS and the DUR Board, in FFY 2017 the DUR program repeated the successful DUR educational outreach intervention focused on metabolic monitoring efforts among children and adolescents taking antipsychotic medications.

XI. E-Prescribing

1. Does your pharmacy system or vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?
    - Yes
    - No

    If the answer to question *1 is "Yes,"* do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

    - Yes, please explain the evaluation methodology in **Attachment 5 – E-Prescribing Activity Summary.** Describe all development and implementation plans/accomplishments in the area of e-prescribing. Include any evaluation of the effectiveness of this technology (i.e., number of prescribers e-prescribing, percent e-prescriptions to total prescriptions, relative cost savings).
    - No

    If the answer *to question 1 is "No,"* are you planning to develop this capability?

    - Yes
    - No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?
    - Yes
    - No

IX. Executive Summary

Executive Summary Fee-For-Service Example (each plan shall provide their own narrative):

The purpose of Drug Utilization Review (DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. California's Medi-Cal DUR program is the responsibility of the Department of Health Care Services (DHCS), and includes prospective DUR reviews, retrospective DUR reviews, and educational interventions for providers and pharmacies.

During federal fiscal year (FFY) 2017, California's Medi-Cal DUR program maintained a DUR Board comprised of four pharmacists and three physicians, meeting OBRA 1990 requirements. The DUR Board held four meetings in FFY 2017, with each meeting divided up into two distinct sections: 1) old business and follow-ups; and 2) new business that included placeholders for updates from DHCS and the DUR Board, drug utilization reports, prospective and retrospective DUR reviews, and descriptions of educational bulletins and/or alerts.

The DUR Board is responsible for advising and making recommendations to DHCS for the Medi-Cal fee-for-service population. For FFY 2017 the DUR Board advised and made recommendations for: 1) prospective DUR criteria review and evaluation; 2) focused retrospective analyses of claims data in order to study drug use in the Medi-Cal fee-for-service population; and 3) the development and implementation of educational interventions to improve drug use in the Medi-Cal fee-for-service population.

Over the course of FFY 2017, the DUR Board reviewed prospective DUR criteria for 55 drugs and comprehensively reviewed the status of all drugs for additive toxicity (AT) and late refill (LR) alerts, as well as ingredient duplication (ID) alerts for quetiapine and emtricitabine. In addition, retrospective DUR criteria for four drug therapeutic categories were reviewed, as well as all over-the-counter (OTC) medications available on the Medi-Cal Contract Drugs List. A total of seven educational bulletins and alerts were published on the Medi-Cal website in order to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A total of four educational mailings were sent to selected prescribers to improve the quality of care for Medi-Cal beneficiaries, and one educational letter was sent to pharmacies to address early refill overrides. Finally, in FFY 2017, the DUR Board continued to collaborate with key state agencies and national experts, and held the first annual academic detailing conference at DHCS.

This Annual Report was prepared through a collaborative effort between the California Department of Health Care Services, the California Drug Use Review Board, Conduent, and the University of California, San Francisco.

Frequently Asked Questions (FAQs)

1. **Will the FAQs be posted on the Medi-Cal DUR website?**

   Answer: Yes. DHCS will post the FAQs on the website once they are finalized.

2. **If MCOs post their provider educational bulletins to their website and/or provider portal and reflect this in their Pharmacy and Therapeutics (P&T) Committee minutes, will it be considered a fulfilment of the educational portion of Final Rule DUR requirement (Title 42, CFR 456, subpart K)?**

   Answer: Yes. DHCS recognizes that managed care organizations may have different committee names (such as P&T Committee) to carry out DUR activities. If provider educational bulletins are posted on MCO's website and/or provider portal and is reflected in their P&T minutes/agenda, this satisfies DHCS requirement of adopting Global DUR's educational bulletins, and partially satisfies the educational portion of Final Rule DUR requirement (42 CFR 456.711).

3. **If a MCO sends a staff member to attend the Global Medi-Cal DUR Board quarterly meetings, does this help to satisfy the DUR requirement?**

   Answer: Yes. This partially satisfies the CMS' Final Rule DUR requirements (42 CFR Part 456, Subpart K). There are two ways of attending the meetings: either in person, or remotely via a webinar. The webinar link is open for registration about three weeks prior to each meeting date.

   MCOs must actively participate, either individually, or by means of an entity selected to represent multiple MCOs (e.g. California Association of Health Plans, Local Health Plans of California).

4. **My MCO has merged with another health plan. Are both health plans required to submit the annual report**?

   Answer: Yes. Both health plans are required to submit the annual report for the portion of the reporting period prior to the merger. After the merger, the merged health plan is responsible for submitting the annual report for the remaining portion of the reporting period.

5. **My MCO contracts with another MCO to perform DUR activities. Am I responsible for reporting my MCO's DUR activities, even though these activities are contracted out to another MCO?**

   Answer: Yes. You are responsible for reporting DUR activities for your MCO even though the DUR activities have been contracted out to another entity.

6. **My MCO performs all DUR activities internally, but also performs other contracted DUR activities for other MCOs. Do I include the contracted DUR activities for the other MCOs?**

   Answer: No. You are only responsible for reporting DUR activities for your MCO.

7. **How many Global DUR Board meetings am I allowed to miss in a given year?**

   Answer: The All Plan Letter (APL) 17-008 does not address missed meetings. It states MCOs must actively participate, either individually, or by means of an entity selected to represent multiple MCOs (e.g. California Association of Health Plans, Local Health Plans of California). An entity may delegate multiple staff members to rotate to attend the Global DUR board meetings, or join an entity selected to represent multiple MCOs, such as the California Association of Health Plans.

8. **Are there other opportunities to ask questions, such as discussions at the Pharmacy Directors meetings?**

   Answer: Yes. There will be more opportunities to ask questions, such as discussions at the Pharmacy Directors meetings or by individual inquiries.

9. **Where are the questionnaire requirements from CMS?**

   Answer: The survey questionnaire was included in the email that was sent to the Pharmacy Directors in April 2018. When the survey questionnaire is posted on the CMS website, DHCS will send forward the website link to the plans.

10. **Is the DUR Annual Survey the only requirement needed to be compliant?**

    Answer: Yes. The DUR Annual Survey plus attachments will fulfil the compliance portion DUR Annual Survey and the APL 17-008.

11. **What are our action items that we will use to complete the survey as stated in the APL?**

    Answer: The Global DUR Meeting MCP Actions (provided after each meeting) lists a summary of required actions for RetroDUR and Educational Bulletins. Include only those items that your MCO has taken action on. Typically, you may include the name, date, and method of dissemination of educational bulletins, and your MCO's DUR activities that occurred outside of the Global DUR Board.

12. What response would be expected from an MCO for questions referring to carved-out drugs?

Answer: Not all plans have carved-out drugs. For carve-out drugs questions, use DHCS provided guidance. Plans with no carved-out drugs to prepare the responses specific to the plan.

13. Would it be possible for DHCS to provide the MCOs with the applicable summary points that address the DUR Board meetings?

Answer: The Global DUR Meeting MCP Actions lists a summary of required actions for RetroDUR and Educational Bulletins. Report only those items that your MCO has taken action on and include the name, date, and method of dissemination. Also include your MCOs DUR activities that occurred outside of the Global DUR Board.

References:

1. CMS Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)
https://www.medicaid.gov/medicaid/managed-care/downloads/mco-cod-presentation.pdf

2. DHCS All Plan Letter 17-008. Requirement to Participate in the Medi-Cal Drug Utilization Review Program.
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-008.pdf

3. Medicaid Managed Care Organization Drug Utilization Review Annual Report Federal Fiscal Year 2018. OMB approved #0938-0659.

4. 42 CFR Part 456, Subpart K- Drug Use Review (DUR) Program and Electronic Claims Management System for Outpatient Drug Claims.
https://www.law.cornell.edu/cfr/text/42/part-456/subpart-K

Global Medi-Cal Drug Utilization Review Board Meeting Pharmacy Updates

Pauline Chan, R.Ph., MBA
Pharmacy Operations Branch
09-18-18

Topics

- Hepatitis C policy revision
- Prescription Drug Overdose Prevention (PDOP)
- Academic Detailing
- Dissemination of DUR Educational Bulletin
- ADURS Recommended Minimum Standards
- Future meeting agenda topics
  - Prospective alerts
  - Pharmacy reimbursement project
  - CURES
  - Medication Assisted Treatment (MAT)

Reflection

"We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right - one after the other, no slipups, no goofs, everyone pitching in."

— Atul Gawande, MD,

Hepatitis C Policy Revision

- Revised July 1, 2018
  - Website: DHCS Policy
  - Provider Manual Update
  - Follows American Association for the Study of Liver Diseases (AASLD) Guidelines AASLD
- Notable change:
  - Treatment to all patients ages 13 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity. Exception: patient with a life expectancy of less than 12 months.

Prescription Drug Overdose Prevention (PDOP)

- Statewide Overarching Strategy:
  1. Safe Prescribing
  2. Access to Treatment
  3. Naloxone Distribution
  4. Public Education Campaign
  5. Data Informed/Driven Intervention

Prescription Drug Overdose Prevention (PDOP)-2

- Measurements
  - Increase number of active buprenorphine prescribers
  - Increase number of naloxone claims
  - Decrease all cause overdose mortality
  - Less use of concurrent benzos and opioids
  - Less use of opioids >MEDD 90mg

Prescription Drug Overdose Prevention (PDOP)-3

- Opioid Overdose Surveillance Dashboard
- California Quick Stats (2017) *updated*
  - All Opioid Overdose Deaths: 1882
  - Fentanyl Overdose Deaths: 373
  - Opioid (exclude heroin) Overdose ED Visits, 4,281
  - Opioid Prescriptions, 21,787,042

Academic Detailing (AD)

- AD Training (April, June, July 2018)
  - Feedback and testimony from participants
  - Training sponsored by California Health Care Foundation & California Department of Public Health
- AD Second Annual Conference October 2017
  - Consensus Workshop*
    - Updates
    - Next steps

* Document attached

Dissemination of DUR Educational Bulletin

- Dissemination of DUR Educational Bulletins by Health Plans:
- Examples
  - Partnership
  - Partnership archived letters
  - Aetna

ADURS Recommended Minimum Standards

- Background
  - CMS is considering setting minimum standards for Medicaid DUR programs
- American Drug Utilization Review Society (ADURS) establishes a list of recommendations
  - Prospective DUR
  - Retrospective DUR

ADURS Recommended Minimum Standards -2

- Retrospective DUR
  - Tracking top drugs, prescribers, pharmacies in an effort to focus education
    - CMS to consider a database for Medicaid recipients in the same structure as Medicare Part D data: Database
    - Provides a wealth of information and comparative data points
    - Includes data from FFS and Managed Medicaid, and carve-outs

ADURS Recommended Minimum Standards -3

- Retrospective DUR
  - Peer comparison/public data
    - State approach
    - National approach
  - Prescriber access to claims history
    - Allow prescriber access to paid claims to improve prescribing and outcomes
      - » multiple prescribers
      - » Refill history

Future Meeting Agenda

- Prospective alerts
- Pharmacy reimbursement project
- CURES
- Medication Assisted Treatment (MAT)

Questions?

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Medi-Cal DUR Board Meeting 09-18-18

DHCS Drug Utilization Review Academic Detailing Conference October 12, 2017
Consensus Workshop Action Plan

	Topic	Resources	Actions 2016	Actions 2017	Actions 2018	Next Steps	Timeline
1	**State and Federal Regulatory Guidance**						
	a. Regulatoy Guidance	Drug Utilization Review (DUR) regulations 438.3(s)(4); 1927(g) of Social Security Act	conference	conference			
	b. State Guidance	Process Development, www.medi-cal.ca.gov DUR main page	conference	conference			
2	**Establish Provider Advisory Group**						
	a. Increase provider awareness	www.medi-cal.ca.gov DUR mainpage	Conference Faculty	Conference faculty			
	b. Provider advisory group		Conference Faculty	Conference Faculty	Pharmacy Directors Panelists		
3	**Provide Tools and Resources**						
	a. AD best practices	www.narcad.org	Conference Faculty	Conference Faculty			
	b. Examples of successful practices	Veteran Administration (VA), Partnership Health Services, NaRCAD, Stanford, San Francisco Department of Public Health (SFDPH)	Veteran Administration (VA), Partnership Health Services, NaRCAD, Stanford, SFDPH	NaRCAD, Stanford			
	c. Offer ideas and topics	Opioids, naloxone	opioids, antibiotics, psychotropic meds	antibiotics			
	d. Provide tools and resources	California Health Care Foundation (CHCF)- California Department of Public Health (CHCF) opioids and naloxone	Conference faculty	Conference faculty			
4	**Training and Development Collaboration**						
	a. Assemble coalition for training and development	Foundation, public health, academia	Conference Faculty	Conference faculty			
	b. Cohorts with common issues	Health Plans					
5	**Standard Expertise and Coaching**						
	a. create standard materials	a. Opioid Stewardship and Chronic Pain: A Guide for Primary Care Providers, b. Opioid Safety: Focus on Furnsihing Naloxone: A Guide for California Community Pharmacists					

DHCS Drug Utilization Review Academic Detailing Conference October 12, 2017
Consensus Workshop Action Plan

	Topic	Resources	Actions 2016	Actions 2017	Actions 2018	Next Steps	Timeline
	b. dedicated plan DHCS coach	Coach from academia, DHCS, SFDPH					
	c. Provide talking points	included in the guide (pull out page)	Conference activity: role play	Conference activity: role play			
	d. Provide training and clinical expereince	training sesssion in April, June and July 2018	Conference activity: role play	Conference activity: role play			
6	**Analytics and Data Support for Measurable Outcomes**						
	a. Analytics and data support	CDPH					
	b. Define goals of AD	Opioids					
	c. Defininf measurable outcomes	Statewide Opioid Workgroup					
	d. Provide collaborative expertise on strategies, measures and analytics						
7	**Program Funding and Support**						
	a. funding events and training (one time)	CHCF-CDPH	conference host DHCS	conference host DHCS	CHCF-CDPH		
	b. funding events and training (ongoing)	NaRCAD	NaRCAD	NaRCAD	NaRCAD		
	c. How to expand AD to management						
	d. Provide program structure						